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of the Michigan State Medical Society

VOLUME 52 JULY, 1953 NUMBER 7

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J. S. DeTar, M.D., Milan.....1953
W. D. Barrett, M.D., Detroit.....1954
W. H. Huron, M.D., Iron Mountain 1954
R. L. Novy, M.D., Detroit.....1954

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G. C. Penberthy, M.D.....Detroit

Alternates

E. F. Sladek, M.D., Traverse City....1953
W. W. Babcock, M.D., Detroit.....1953
E. C. Texter, M.D., Detroit.....1953
E. D. Spalding, M.D., Detroit.....1954
C. I. Owen, M.D., Detroit.....1954
G. W. Slagle, M.D., Battle Creek.....1954

AMA Annual Session - June 1953

The annual session of the American Medical Association was held in New York, New York, June 1, 2, 3, 4, 5, 1953. As usual the session was preceded by many other national and other types of medical meetings. One of the most impressive was the Ninth Annual Conference of Presidents and other officers of State Medical Societies. This conference was first organized by Andrew S. Brunk, M.D., of Michigan. Dr. Louis M. Orr, of Orlando, Florida, in his inaugural, urged medical societies to continue, and accelerate, the expansion of the medical profession's many constructive programs now under way to make good medical care available to all the American people. Speakers were the Rev. Frank W. Price, Chinese missionary; Senator John Marshall Butler, of Maryland, who spoke on "the Constitution and the Treaty-Making Powers."

The first action of the House of Delegates in session was the selection of the winner of the Distinguished Service Award, Alfred Blalock, M.D., of Baltimore, for his outstanding work in vascular surgery.

In a brief appearance Mrs. Oveta Culp Hobby said universal medical care provided by the government not only threatens the democratic principle, but is uneconomic and inherently self-defeating.

Hard at work in the AMA House of Delegates, meeting June 1–4 in New York City, are members of the MSMS delegation. Front row (left to right), Delegates: J. S. DeTar, M.D., Milan; W. D. Barrett, M.D., Detroit; Wm. A. Hyland, M.D. (Chr.), Grand Rapids; R. L. Novy, M.D., Detroit; R. A. Johnson, M.D., Detroit; W. H. Huron, M.D., Iron Mountain; G. C. Penberthy, M.D., Detroit. Second row (left to right), Alternate Delegates: G. W. Slagle, M.D., Battle Creek; E. C. Texter, M.D., Detroit; C. I. Owen, M.D., Detroit; E. F. Sladek, M.D., Traverse City; E. D. Spalding, M.D., Detroit. Not present on this occasion was Alternate Delegate W. W. Babcock, M.D., Detroit. In center background behind delegation can be seen R. J. Hubbell, M.D., Kalamazoo, MSMS President, and Wilfrid Haughey, M.D., Battle Creek, Editor, THE JOURNAL, MSMS.

Mrs. Hobby, Secretary of the Department of Health, Education and Welfare, expressed the need for a "close partnership between the government, the people and the medical profession" to achieve a better health care for the people of the United States. Mrs. Hobby hailed the splendid medical care now provided under a private voluntary medical system, but pointed out that every advance brings its own problems.

"The changing medical practice and a changing society have presented us with an embarrassing

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Meat and its applicability in the Dietary Management of Atherosclerosis

Contrary to the former belief that serum cholesterol levels are primarily related to ingested animal fat and consequently to dietary cholesterol, it now appears that the total amount of fat in the diet, not its source or cholesterol content, is a more important factor in determining the blood cholesterol concentration.[1,2,3,4] Clinical observation has shown that ingestion of vegetable fat—which contains no cholesterol—will, like fats of animal origin, raise the serum cholesterol level.[3,5]

Recent basic research on the influence of fats and cholesterol on human health has done much to further progress in the fight against atherosclerosis. It will serve well in dispelling the mistaken fear that reasonable amounts of foods of animal origin predispose the individual to this vascular disease.[6] As a matter of fact, a dietary inadequate in essential nutrients but providing too many calories and too much fat from *any* source may well be an important factor underlying the deposition of fat and cholesterol in the arteries and liver.

Cumulative evidence indicates that lowered blood levels of cholesterol may be effected by restricting the total fat intake.[1] Except in instances of refractory hypercholesteremia, in which a daily fat intake as low as 10 Gm. may not reduce cholesterol levels to normal, diets containing 20 to 30 Gm. of fat, or even more, often produce low cholesterol blood levels. In the clinical application of this principle, various palatable, low fat diets which supply three servings of meat daily (containing 18 Gm. of fat) have recently been suggested for the dietary management of arteriosclerosis and for enlisting the cooperation of patients.[1] The meat servings were chosen from a large variety of cuts and kinds of meat (fat trimmed off, as lean as possible). Meat adds to the eating appeal of the fat-restricted diet and contributes important amounts of biologically complete protein, the B group of vitamins including B_{12}, and food iron—all of which are important for a good state of nutrition in the atherosclerotic patient.

1. Hildreth, E.A.; Hildreth, D.M., and Mellinkoff, S.M.: Principles of a Low Fat Diet, Circulation 4:899 (Dec.) 1951.
2. Bloch, K.: The Intermediary Metabolism of Cholesterol, Circulation 1:214 (Feb.) 1950.
3. Keys, A.; Mickelson, O.; Miller, E.V.O., and Chapman, L.B.: The Relation in Man Between Cholesterol Levels in the Diet and in the Blood, Science 112:79, 1950.
4. Gubner, R., and Ungerleider, H.E.: Arteriosclerosis, a Statement of the Problem, Am. J. Med. 6:60, 1949.
5. Hildreth, E.A.; Mellinkoff, S.M.; Blair, G.W., and Hildreth, D.M.: The Effect of Vegetable Fat Ingestion on Human Serum Cholesterol Concentration, Circulation 3:641 (May) 1951.
6. King, C.G.: Trends in the Science of Food and Its Relation to Life and Health, Nutrition Rev. 10:1 (Jan.) 1952.

(Continued from Page 694)

number of what are paradoxically problems of progress," she said. "There is little controversy on our objective—the best medical care possible for the people. It is the means to this end which raise the problems we face in achieving this purpose."

The House of Delegates unanimously adopted a recommendation of its Reference Committee on Insurance and Medical Services that, except in cases involving tuberculosis or psychiatric or neurologic disorders, responsibility for the care of veterans with disabilities or diseases of non-service-connected origin should be returned to the individual and to the local community.

In taking this action the House of Delegates adopted the same recommendations which were presented and deferred last December in Denver by a special committee on federal medical services appointed the previous year by the board of trustees.

In defining the basic question involved the committee expressed the belief that "the medical profession must concern itself, not with the number of 'chiselers' in Veterans Administration hospitals nor with the efficacy of the Veterans Administration in the administration of enabling legislation, but rather with the broad question of whether such legislation is sound, whether the federal government should continue to engage in a gigantic medical care program in competition with private medical institutions and whether the ever-increasing cost of such a program is a proper burden to impose on the taxpayers of the country."

In conclusion the committee stressed the fact that it was raising no question concerning the present program of hospitalization and medical care for veterans with service-connected disabilities. The committee and the House restated their hearty endorsement of this program.

During the House of Delegates meeting, Wednesday, June 3, Dr. Robert L. Novy, President of Michigan Medical Service, and Vice President of the National Blue Shield, introduced the 26,000,000th member of the Blue Shield. He is William P. Marcum, of Louisville, Kentucky, who was flown to New York for the occasion. On June 9, he was to be honored in his own state by a dinner.

The House reaffirmed its approval of Senate Joint Resolution number one providing that treaties or executive agreements may not supercede the constitution or the laws of the nation or states. That condition now prevails.

E. J. McCormick, M.D.

Edward J. McCormick, M.D., President-elect, in his address to the House outlined ten principles for his plan for Medical Care. His inaugural address was a masterpiece, and was broadcast to the nation. Cardinal Spellman gave the invocation at the inaugural meeting of the House.

Walter B. Martin, M.D., of Norfolk, Virginia, a member of the Board of Trustees was elected President-elect, and Julien P. Price, M.D., of Florence, South Carolina, editor of the South Carolina *Journal,* to the unexpired term on the AMA Board of Trustees.

The attendance exceeded anything in history; 17,958 Doctors of Medicine were registered, with 31,022 guests, exhibitors, et cetera.

You and Your Business

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
Pantlind Hotel-Civic Auditorium, Grand Rapids
Wednesday-Thursday-Friday, September 23-24-25, 1953
YOU ARE URGED TO ATTEND!

TWENTY-SEVEN GUEST SPEAKERS FOR ANNUAL SESSION

The Michigan State Medical Society Annual Session will be a gathering of some 3,000 medical folk at the Pantlind Hotel-Civic Auditorium, Grand Rapids, September 23-24-25, 1953. No registration fee is charged to MSMS members who are urged to secure their reservations now by writing L. E. Ames, Secretary, Committee on Hotels, c/o Pantlind Hotel, Grand Rapids.

Twenty-eight guest essayists, from all parts of the United States, will be presented on the 1953 program, including: U. S. Senator Homer Ferguson, Washington, D. C.; AMA President Edward J. McCormick, M.D., Toledo; J. A. Bargen, M.D., Rochester, Minn.; Allan C. Barnes, M.D., Cleveland, Ohio; William L. Benedict, M.D., Rochester, Minn.; Paul R. Cannon, M.D., Chicago, Ill.; John G. Downing, M.D., Boston, Mass.; O. Spurgeon English, M.D., Philadelphia, Pa.; Everett I. Evans, M.D., Richmond, Va.; David P. Findley, M.D., Omaha, Neb.; Arthur T. Hertig, M.D., Boston, Mass.; Frank Hinman, Jr., M.D., San Francisco; Blair Holcomb, M.D., Portland, Ore.; Wm. D. Holden, M.D., Cleveland, Ohio; Chevalier L. Jackson, M.D., Philadelphia, Pa.; Julian Johnson, M.D., Philadelphia, Pa.; Norman M. Keith, M.D. Rochester, Minn.; John W. Knutson, D.D.S., Washington, D. C.; Louis A. M. Krause, M.D., Baltimore, Maryland; Walter G. Maddock, M.D., Chicago, Ill.; Harold J. Magnuson, M.D., Chapel Hill, N. Carolina; Michael L. Mason, M.D., Chicago, Ill.; Victor A. Najjar, M.D., Baltimore, Md.; Leo G. Rigler, M.D., Minneapolis, Minn.; Harrison Sadler, M.D., Grosse Pointe Farms; George E. Shambaugh, Jr., M.D., Chicago, Ill.; Leo M. Taran, M.D., Roslyn, N. Y.; and Henry Welch, Ph.D., Washington, D. C.

The Presidents, Secretaries and Executive Secretaries of neighboring state medical societies and of the Ontario Medical Association also are being invited to the 88th Annual Session of the Michigan State Medical Society.

TEMPORARY LICENSURE

Following is an explanation of the two types of temporary licensure issued by the Michigan Board of Registration in Medicine and the credentials needed for each:

Temporary Licensure for Postgraduate Work in an Approved Training Hospital—This temporary license was made possible by Senate Bill No. 301 which, when passed by the Michigan Legislature in 1952 and signed by the Governor, became Public Act No. 172 of 1952.

Temporary licensure for postgraduate work in an approved training hospital may be issued to applicants with the following credentials:

1. Graduation from an approved class-A medical school in the United States or Canada.
2. Certification of an approved internship served in the United States or Canada.
3. For foreign graduates—fulfillment of extra educational credentials as per the Rules and Regulations, Paragraph H, and a certified approved internship in the United States or Canada.

All trainees, which includes interns, assistant and resident physicians are exempt from the basic science certificate requirement by the basic science law which states, ". . . this act shall not be construed as applying to interns and residents who are training in Michigan hospitals."

Temporary Licensure for Private Practice—Doctors holding this license enjoy all the privileges of a fully licensed doctor of medicine with permanent Michigan license. The requirements are the same as itemized above for the temporary license for postgraduate work plus the following:

1. Basic science certificate, unless exempt.
2. Completed Endorsement Application with $100 fee on file in our office, or successful Michigan licensure examination with fee, $50.

(Since these applicants are no longer trainees, they are not exempt from the basic science requirement.)

Temporary licensure, both for postgraduate work and private practice is to be issued for a period not to exceed five years and must be renewed annually at $10 per annum.

Temporary license for private practice was made possible by Senate Bill No. 1261, of 1953, *but is limited* by the bill to *Canadian citizens* with Canadian credentials or *DP doctors* who entered the United States under the DP act of 1948 and have resided in Michigan since January 1, 1952.

MICHIGAN STATE BOARD OF
May 25, 1953 REGISTRATION IN MEDICINE

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL May 20, 1953

Seventy-four items were presented to the Executive Committee of The Council on May 20. Chief in importance were:

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To open congested air passages in hay fever

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A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

The resultant relief to the hay fever sufferer is decidedly gratifying. Prolonged action of Neo-Synephrine makes fewer applications necessary, consequently longer periods of rest and sleep are possible.

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Neo-Synephrine is practically free from sting and compensatory congestion; does not appreciably inhibit ciliary activity. Neo-Synephrine has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.[1]

Supplied in 0.25% solution (plain), bottles of 1 oz., 4 oz. and 16 oz.; 0.25% solution (aromatic), bottles of 1 oz. and 16 oz.; 0.5% solution, bottles of 1 oz.; 1% solution, bottles of 1 oz., 4 oz. and 16 oz.; 0.125 (⅛)% solution, bottles of ½ oz.; 0.5% water soluble jelly, in ⅝ oz. tubes.

1. Van Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 698)

- *Beaumont Memorial Restoration.*—The following matters were considered: (a) cornerstone laying is scheduled for Friday, July 17, 1953, at 3:00 p.m., Mackinac Island, with a simple ceremony; (b) the Beaumont Memorial Working Committee, W. S. Jones, M.D., Chairman, will meet to inspect progress on the new museum on Saturday, July 18; (c) Report was made that state-wide, approximately 35 per cent of MSMS members have contributed to the Beaumont Memorial but only 17 per cent (384 members) in Wayne County have donated to the Memorial, to date. The Beaumont Memorial Committee was requested to continue the solicitation of funds, until assured that sufficient monies to erect the building and to secure the property surrounding the Beaumont Memorial have been secured; more than just the cost of erecting the building is needed to insure proper landscaping and perspective of this beautiful Memorial.
- *Remodeling* of the porch and reception room of the MSMS home at 606 Townsend, Lansing, was authorized.
- *Committee Reports.*—The following were given consideration: (a) Permanent Conference Committee, meeting of April 22; (b) Advisory Committee to National Foundation for Infantile Paralysis, April 22; (c) Child Welfare Committee, April 29; (d) Cancer Control, April 30; (e) Rural Medical Service, April 30; (f) Medical Advisory Committee to Michigan Hospital Service, April 30; (g) Committee on Scientific Work, May 6. Also presented were the minutes of the Board of Michigan State Medical Assistants Society, meeting of May 19.
- *President-Elect Hull* reported that the Genesee County Medical Society Cancer Conference of April 8 was a very successful and informative scientific session. A congratulatory letter was authorized to be sent to the Genesee County Medical Society and to the sponsor of its Cancer Conference, Mr. Donald E. Johnson, Flint, member of the Board of Directors of the American Cancer Society.
- *Special Invitations to MSMS Annual Session.*—The Executive Committee of The Council authorized the processing of special invitations to Presidents, Secretaries and Executive Secretaries of neighboring state medical societies and of the Ontario Medical Association to all MSMS Annual Sessions in future.
- *President R. J. Hubbell, M.D.,* reported that U. S. Senator Homer Ferguson had accepted invitation to present the Biddle Lecture in Grand Rapids on Thursday, September 23, 1953, Black and Silver Ballroom, Civic Auditorium, G. R.
- *Invitation to nominate a Michigan physician* for Award during President's Committee on Nationally Employ the Physically Handicapped Week, was referred to the Michigan Industrial Medical Association, for recommendations.
- *Health and Accident Insurance Studies.*—Letter from the Wayne County Medical Society Insurance Studies Committee, recommending a joint meeting with the MSMS Committee on Group Health and Accident Insurance Studies, was referred to the latter committee.
- *Congratulatory letter to the General Electric Company* on its excellent advertisements to the laity, in connection with its x-ray department, was authorized.
- *Report of J. S. DeTar, M.D.,* Milan, on the Conference on Financing Hospital Care, Chicago, April 24-25, was accepted with thanks.
- *C. Allen Payne, M.D.,* Grand Rapids, was appointed Chairman of the Scientific Exhibit for MSMS Annual Session, September 23-24-25, 1953, in Grand Rapids.

  Chairmen of Annual Session Assemblies were appointed as follows: W. A. Hyland, M.D., Grand Rapids, H. H. Hiscock, M.D., Flint, R. J. Hubbell, M.D., Kalamazoo, J. E. Livesay, M.D., Flint, F. H. Drummond, M.D., Kawkawlin, J. D. Miller, M.D., Grand Rapids. Secretaries of Assemblies: J. M. Wellman, M.D., Lansing, L. L. Loder, M.D., Muskegon, L. Fernald Foster, M.D., Bay City, C. J. Williams, M.D., Grosse Pointe, J. P. Ottaway, M.D., Detroit, F. A. Lamberson, M.D., Detroit, and M. G. Butler, M.D., Saginaw.

  Discussion Conference Leaders: R. W. Buxton, M.D., Ann Arbor, on Wednesday; Arch Walls, M.D., Detroit, on Thursday, and A. A. Humphrey, M.D., Battle Creek, on Friday.
- *1954 Michigan Clinical Institute.*—Annual Heart Day (Friday morning, March 12, 1954) will include a scientific program arranged by the Michigan Heart Association; the Executive Committee of The Council accepted with thanks the invitation of the M.H.A. in this regard.
- *The Annual County Secretaries-Public Relations Conference* is to be held at the Sheraton-Cadillac Hotel, Detroit, January 31, 1954.
- *The usual financial help* in sending representatives of the Student American Medical Association at the University of Michigan and at Wayne University, to attend the SAMA convention in Chicago in June, 1953, was authorized.
- *Publicity in JMSMS and in Secretary's Letter* to all members on practical nurse program sponsored by the Michigan Department of Public Instruction was approved.
- *Social Security.*—A poll, asking MSMS members if they desire Social Security for themselves, was authorized to be inserted in the next Secretary's Letter to All Members; from this infor-

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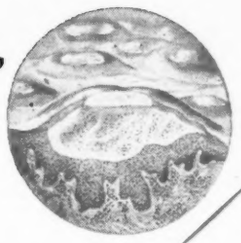
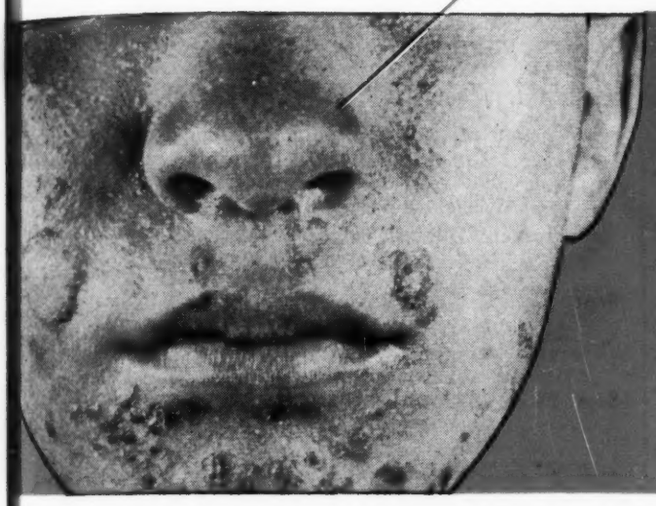
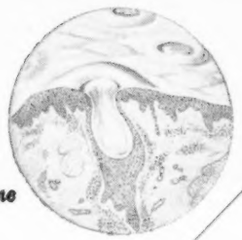




skin infections and antibiotics



Since cutaneous bacterial infections "probably account for more disability than any other group of skin diseases,"[1] the availability of broad-spectrum Terramycin has been particularly helpful in controlling these common disorders. This pure, well-tolerated antibiotic is markedly effective against the wide range of organisms often implicated as primary or secondary pathogens in skin disease. Successful clinical experience[2,3,4] in the treatment of impetigo, acne, pyodermas, erythema multiforme and other cutaneous infections recommends the selection of Terramycin as an agent of choice in common diseases of the skin. Terramycin is supplied in convenient oral and intravenous dosage forms.

1. *Bednar, G. A.: South. M. J. 46:298 (March) 1953.*
2. *Wright, C. S. et al.: A. M. A. Arch. Dermat. & Syph. 67:125 (Feb.) 1953.*
3. *Robinson, H. M. et al.: South. M. J. (in press).*
4. *Andrews, G. C. et al.: J. A. M. A. 146:1107 (July 21) 1951.*

Terramycin

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HIGHLIGHTS OF THE COUNCIL

(Continued from Page 700)

mation, the MSMS House of Delegates and The Council will be properly guided when action on this subject is necessary.

- *Report of J. E. Livesay, M.D.,* Flint, on proposed x-ray radiation course to be held at Michigan State College, East Lansing, June 29-30, 1953, was presented and accepted with thanks.
- *A joint meeting* with Michigan's seven Delegates to the AMA House of Delegates was held: problems, resolutions and other matters that may be presented to the AMA in New York City, June 1-5, 1953, were discussed.
- *Treasurer's Report.*—A progress report on bonds of the Michigan State Medical Society was presented by Treasurer Wm. A. Hyland, M.D., Grand Rapids.
- *Legal Counsel's Report.*—Mr. J. Joseph Herbert presented opinions on the following matters: (a) the legality of chiropodists giving hypodermic injections; (b) creation of a registry of the blind by the Michigan Department of Health; (c) payment of fees to surgical assistants.
- *The monthly report of the Rheumatic Fever Co-ordinator,* Leon DeVel, M.D., Grand Rapids, was presented and accepted.
- *Suspension and Revocation of License.*—What should be done by County Medical Societies when a member thereof has his license either suspended or revoked by the Michigan State Board of Registration in Medicine? This question was thoroughly discussed and it was felt that it should be the subject of further discussion at the annual County Secretaries Conference January 31, 1954.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physicians' groups in Michigan, follows:

1953

Aug. 20 Third Annual Clinic, Central Michigan Committee, ACS Michigan Committee on Trauma, plus Michigan National Guard Medical Personnel, and Michigan Society of North Central Counties — Grayling

Sept. 22 Michigan Chapter, American College of Surgeons — Grand Rapids

Sept. 23-25 MSMS ANNUAL SESSION — Grand Rapids

Oct. 7 Clara Elizabeth Fund for Maternal Health and Genesee County Medical Society — Flint

Oct. 21 Michigan Cancer Conference — East Lansing

Autumn MSMS Postgraduate Extramural Courses — Statewide

1954

Mar. 10-12 MICHIGAN CLINICAL INSTITUTE — Detroit

Apr. 14 Genesee County Medical Society Ninth Annual Cancer Day — Flint

May 12 Annual Clinic Day and Alumni Reunion of the Wayne University College of Medicine, Hotel Fort Shelby — Detroit

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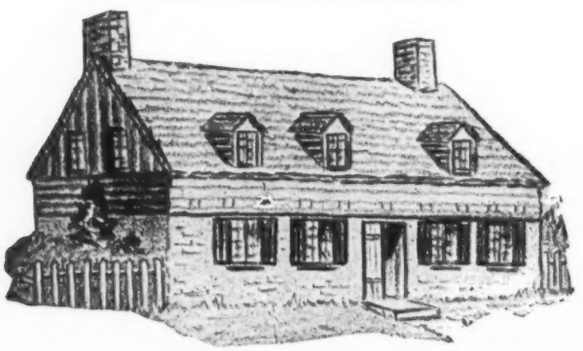
Proposed

BEAUMONT MEMORIAL



"A little from many will build the Beaumont Memorial—a monument to the generosity of Michigan's medical men."—Otto O. Beck, M.D.

Beaumont Memorial Restoration Committee
Box 539, Lansing 3, Michigan

I attach my check in the amount of: $.....
OR
I pledge the amount of: $.....

payable on or before.....
to assist my fellow doctors of medicine of Michigan in building the Beaumont Memorial on Mackinac Island, Michigan.

..... M.D.

.....
street

.....
city state

Some questions about filter cigarettes that may have occurred to you, Doctor

and their answers by the makers of Kent

Q: What materials are used in cigarette filters?

A: Until just recently, cellulose, cotton or crepe paper were the only materials used in cigarette filters.

Now, after long search and countless experiments, KENT's "Micronite"* Filter has been developed. It employs the same filtering material used in atomic energy plants to purify the air of minute radio-active particles.

Q: How effective are these cigarette filters?

A: Scientific measurements have proved that cellulose, cotton or crepe paper filters do not take out a really effective amount of nicotine and tars.

However, these same tests also have proved that KENT's exclusive Micronite Filter *approaches 7 times the efficiency of other filters in the removal of tars and nicotine* and is virtually twice as effective as the next most efficient cigarette filter.

Q: Do physiological reactions to filter cigarettes differ?

A: The drop in skin temperature occurring at the finger tip induced by filtered cigarette smoke was measured according to well-established procedures. (a, b)

For conventional filter cigarettes, the drop was over 6 degrees. For KENT's Micronite Filter, there was no appreciable drop.

Q: Does an effective cigarette filter also remove the flavor?

A: KENT's Micronite Filter . . . the first cigarette filter that really works . . . lets smokers enjoy the full pleasure of a really fine cigarette, yet gives them the greatest protection ever from tars and nicotine.

In less than a year's time, the new KENT has become so popular it outsells brands that have been on the market for years.

• • •

Today, KENTs are sold in most major U.S. cities. If your city is not yet among them, simply write to P. Lorillard Co., 119 West 40th Street, New York, N. Y., and special arrangements will be made to assure you of a regular supply.

References Cited

a. *J.A.M.A.*, Vol. 103, 1934, p. 318
b. *J.A.M.A.*, Vol. 135, 1947, p. 417

* PATENT APPLIED FOR

Scholarships in Michigan

AT UNIVERSITY OF MICHIGAN

Roy Bishop Canfield Memorial Fellowship in Otolaryngology

Established in 1932 through the generosity of Mrs. R. B. Canfield, in memory of her husband's years of devotion to his department and in order that the influence which he had during his twenty-eight years of service in the Medical School may be continued in the training of young graduates to carry on work in otolaryngology.

The interest on the endowment of $35,000 is to "be given to young men physically and mentally equipped, but perhaps financially unable, to carry on with honor work in this special field of medicine—young men not only of ability but of such sincerity of purpose and of effort that they will uphold the high standards to which Doctor Canfield pledged himself." The holder of this fellowship in 1942-1946 was Doctor William N. Sauer.

Edward Swift Dunster Fellowship In Obstetrics and Gynecology

Totaling $1,500 in 1936 and increased to $3,230 in 1938, this fellowship was donated by the children of the late Edward Swift Dunster, for the purpose of establishing and maintaining a fellowship in the Medical School in honor of their late father, who was for many years and at the time of his death, Professor of Obstetrics in the Medical School.

Dr. Louis Merwin Gelston Fellowship

Established in 1936 by bequest of Lucia C. Gelston, Ann Arbor, Michigan, as a memorial to her husband, Louis Merwin Gelston, A.B., '01, Ph.D., '03, M.D., '05. The annual income is to be used for one or more postgraduate research fellowships in the field of medical science, or in other fields as closely allied thereto as feasible. The medical faculty sets the length of time in which one person may be benefited by the fellowship. The amount of such fellowship or fellowships shall be determined by the Regents upon recommendation of the Medical School faculty. In case there is a member or members of the Nu Sigma Nu fraternity who have shown exceptional ability in medical research and who wish to carry on such research work after graduation, he or they shall have preference over others seeking such awards.

George Slocum Research Fund

Established in 1933 by the will of the late Professor George Slocum. One half of the income from $1,000 is to be added to the Weeks research fund annually. The other half of the income is to be added to the principal until such time as the total income shall amount to $1,000 a year, at which time the whole income may be used for research in ophthalmology.

John E. Weeks Scholarship for Research Work in Ophthalmology

Established in 1921 by a gift of $10,000, income from which is awarded annually.

Walter R. Parker Scholarship

In 1936, by bequest of the late Margaret Watson Parker, Detroit, Michigan, wife of Doctor Walter Robert Parker, B.S. (Mech. E.), '88, formerly professor of ophthalmology in the Medical School, a fund of $30,000 was provided for the establishment of this scholarship in ophthalmology. Candidates for appointment must be graduates of a Class A medical school, must have completed one year's rotating internship in a hospital accredited by the American Medical Association, and must be eligible to enroll in the Horace H. Rackham School of Graduate Studies. The scholarship is administered by a committee consisting of the President of the University, the Dean of the Medical School and the Professor of Ophthalmology. Candidates should apply to the Professor of Ophthalmology before December 1 of the year preceding the year (July 1 to June 30) in which the scholarship will be held.

John Harper Seeley Fellowship Fund

Established by Mr. and Mrs. Halstead H. Seeley in memory of their son, John Harper Seeley. This fellowship was established to provide fellowships for graduate students in medicine.

AT WAYNE UNIVERSITY COLLEGE OF MEDICINE

Wayne University has in the College of Medicine thirteen graduate teaching assistantships which are used primarily for graduate work in our college. These positions pay $3,104 annually.

It also has a Postgraduate Scholarship Award given out yearly by the Alumni Association to a recent graduate for the best scientific work done during the year.

Cancer Comment

MASKED INTERNAL CANCER SYMPTOMS—LYMPHOBLASTOMA

One of the problems facing the busy medical practitioner is the early detection of internal cancer. That group of diseases encompassed under the heading of *lymphoblastoma* is a good example of this difficult diagnostic problem. Not only does this disease present variable symptomatology but those clear-cut findings such as blood changes and positive lymph node enlargement are slow to make their appearance in many instances. The lymphoblastomas, which include the leukemias, Hodgkin's disease, lymphosarcoma and a few other variants, may be aptly referred to, therefore, as a group of internal cancers with masked symptoms.

Fever, often in the form of night sweats, is one symptom which should not be neglected. Usually one does not relate fever to cancer until the later disease stages are reached or until the neoplasm has picked up a moderate amount of infection. The mechanics of fever production is usually one of toxin released from cancer tissue breakdown. A favorite site for such toxin release is in the deep non-palpable retroperitoneal lymph nodes. In fact, it is the involvement of these same nodes that sometimes causes the night sweats of tuberculosis.

A concept that retroperitoneal node invasion in many cases of lymphoblastoma is an early feature, if not the origin of the cancer transformation, permits one to rationalize fever as a masked symptom. Recognition of the presence of deep nodes may also influence the plan of treatment of the disease. It is so easy to direct treatment towards visible or obvious adenopathy at the expense of equally significant internal involvement.

Constipation is a second significant symptom of lymphoblastoma cancer. Here again this symptom is commonly hidden by virtue of its frequency in so many every-day non-cancerous patients. True, we have modern cancer education to thank for reminding us of "any change in bowel habits," but it is so easy to relate this diagnostic hint to just that older group of patients who are more inclined to develop cancer of the colon. And how often has the completely "silent" adenocarcinoma of the splenic flexture confused physicians by causing very little change in bowel habits. Likewise the masked symptom of constipation is confusing in the younger patient with unsuspected lymphosarcoma. Enlarged retroperitoneal lymph nodes again are often the actual cause of the increasing constipation.

Pruritus and fatigue are two other symptoms which are apt to be overlooked in early lymphoblastoma. In this connection one recalls to mind the old teaching that the skin may often be considered as a "mirror" of the functioning ability of the internal body organs. Truly, it is somewhat more difficult to inter-relate the pruritus or the later developing exfoliative dermatitis to associated retroperitoneal invasion even though we know by experience the two are often concurrent. Fatigue is, of course, the result of the toxic effects of the disease.

Abatement of the patient's fever, constipation, and pruritus follows x-ray treatment to the lumbar areas much more frequently than treatment given just over the local superficial nodes. Lymph nodes in the neck and axillae will disappear without direct treatment to them. Occasionally, the converse is true in which superficial hypertrophied nodes will appear to be quite radioresistant until a few treatments are directed retroperitoneally.

This lymphoblastoma disease, striking at almost any age and frequently in a most insidious manner, may quite aptly apply for the title of internal cancer with masked symptoms.

Fever, constipation, fatigue, and pruritus existing often in the absence of blood changes and superficial adenopathy are common though unstriking symptoms. Would a concept of early invasion of retroperitoneal areas in many cancers of the reticuloendothelial system assist the examining physician in his office to keep certain masked symptoms in focus?

Most cancer quacks make some pretense of religion; religion is not regulated by law, and the public seldom questions the honesty or sincerity of one who claims to be an ordained minister or priest.

* * *

It is impossible to rid the world of quacks. So long as we have desperate patients we shall have quacks. But the physician can conduct a three-pronged offensive against the cancer charlatan: he can supply his patients and the general public with correct information; he can give utmost attention to all cancer patients, regardless of prognosis; and he can offer hope. In short, he can beat the quack at his own game.

* * *

Desperation is born of fear, and as cancer is among the most feared of all diseases, cancer victims offer a fertile field to the charlatan.

* * *

The best means available to combat the quack is aggressive therapy or, when that is not possible, time-consuming personal attention on the part of the physician.

Novel Michigan Loan Fund Brings Doctors to Rural Areas

Michigan—through a generous loan fund—has found a partial solution to the problem of supplying doctors of medicine to rural areas of this state.

Often the supply of M.D.'s in outlying sections of the state does not adequately serve the needs of the people in those sections. Some years ago, the Michigan Foundation for Medical and Health Education became aware of this need and in 1948 established a revolving loan fund called the "Fund for Encouragement of Medical Practice in Rural Areas."

The program is administered by a Qualifications Committee composed of four outstate M.D.'s with a practical awareness of rural needs who advise the Board of Trustees of the Michigan Foundation for Medical and Health Education, plus the Deans of Michigan's two Medical Schools. Senior medical students, interns or residents in hospital service who require financial aid are eligible for the loans.

The requirements for a loan, however, help provide added medical service to the rural areas of Michigan. To secure the money the applicant is expected to practice in a rural area for a minimum of three years. A rural area under the terms of the Fund is any town of 5,000 population or less. The loan is without interest until the end of the applicant's first year of medical practice.

The loans are extremely flexible. In fact, they are tailor-made to fit the needs of the particular resident, intern or upperclass medical student. Some loans supplement living expenses; others pay for tuition; others special expenses of medical education.

The Qualifications Committee considers that each loan is merely an "Assist" to the recipient in that the money received from the Foundation is added to the current income of the resident or intern or upperclassman in medical school. It serves to "keep his head above water" financially.

Because each financial situation varies, the loans are far from uniform. One M.D.-to-be is receiving $400 twice each year to help pay his tuition in medical school; another is loaned $50 a month the year around; a third gets $100 per month during the school year and so on. Loans fit the needs. They are tailor-made.

No matter the amount of the loan or how it is dispensed, the youthful recipient generally follows this pattern: he starts practice in the rural area, as stipulated; most often the new M.D. remains after the three-year period is over to continue the enjoyment of friendly people, appreciative patients, excellent fishing and hunting and the relaxation opportunities available in outdoor Michigan—especially in the northern area of the state. This period as general practitioners tends to make better doctors of the M.D.s as it extends their education to include general practice whether they remain as G.P.s or later enter specialties. And the people themselves benefit by the Foundation's plan of interesting doctors to practice in rural areas.

The Michigan Foundation for Medical and Health Education through its Loan Fund is providing a service to the State of Michigan. Actually the value of the money expended as loans cannot be measured in cold cash because its true value can only be gauged in the gratitude of the people who are given rural general practitioners.

NATIONAL ECONOMICS

A recent report shows that $246,000,000 was paid to some two and one-half million farmers under agricultural conservation programs in the 1950-51 fiscal year. The purpose was to pay the farmer to engage in conservation activities.

As usual, Michigan, a high ranking state in terms of revenue paid to the Federal Government, is forty-sixth in terms of average amounts paid to farmers under this scheme, with an average of $60.50; Arizona ranked first with $758.63.

Sidelights on the effect of the steel strike of 1952 show a loss of 5,000,000 tons of steel according to the U. S. Steel Corporation report. The wage loss was $41,000,000, and the government lost $281,000,000 in taxes. State and local taxes dropped $7,000,000.—PAUL SHAFER, M.C.

PR REPORT

Annual Session Publicity

Sound press relations are an important part of any annual meeting of an organization.

Good publicity about the organization establishes the good-will and friendship so necessary to the continued successful operation of the association.

Keeping that in mind, great effort and thought goes into publicity for the annual meetings of the Michigan State Medical Society—the Michigan Clinical Institute, in March, and the Annual Session, in September. Since this issue of THE JOURNAL is devoted to information on the 1953 Annual Session at Grand Rapids, these are the steps taken publicity-wise for the meeting.

Briefly the publicity for the Annual Session can be divided into the two main classifications—Advance Publicity and Publicity During the Annual Session.

Planning the Advance Publicity for the September Annual Session begins in April. A timetable of news releases to medical publications, newspapers, and radio stations is developed. Many factors are considered in the development of this schedule. Since the medical publications include County Medical Society Bulletins in Michigan and surrounding states, THE JOURNAL of the American Medical Association and medical specialty group publications in Michigan, the deadline for sending releases to these groups is considerably ahead of the time necessary to send to newspapers. Thus the medical publications begin receiving stories on the meeting the last of May.

The releases to newspapers and radio stations begin the last week of August and continue once a week until the Annual Session is held. The first release announces the meeting. The other releases are localized to individual newspapers where possible and give prominence to the names of M.D.'s taking part in the meeting as speakers, discussion conference leaders, House of Delegates members, et cetera.

In addition to advance releases to publicize the meeting, a press room is maintained during the Annual Session (and the MCI). This serves as a focal point for the press to gather and interview the speakers plus receiving the service of members of the Press Committee in answering technical questions.

One week prior to the meeting a press dinner is held for members of the press located in the area where the Annual Session is to be held. At this meeting press kits containing all information necessary for complete coverage of the meeting are distributed.

The excellent response of news coverage by papers all over Michigan attests to the value of well-planned press and publicity relationships.

New PR Field Secretary

Dwight D. Jarrell, former Grand Rapids newsman *(The Herald),* returned to the Detroit office of MSMS on June 1, after completing duties in Lansing. Mr. Jarrell replaced Daniel E. Ford as MSMS Public Relations Field Secretary in the Detroit and Southeastern Michigan area.

The new MSMS staff member will be visiting individuals and counties in his district shortly.

Mr. Jarrell was with the Grand Rapids *Herald* for five years before joining MSMS. He attended Michigan State College and was in the Air Force during World War II.

PR Capsules

In continuing MSMS practice of maintaining liaison with other organizations, H. B. Zemmer, M.D., Lapeer; MSMS Legal Counsel J. Joseph Herbert, of Manistee; and MSMS Public Relations Counsel, Hugh W. Brenneman, were appointed to the governing board of Girlstown. The Girlstown project, founded by the Girlstown Foundation, is a program of the Michigan Federation of Women's Clubs which seeks to establish a home for girls. It is in some ways similar to the famous Boystown.

* * *

Benton Harbor's Radio Station WHFB & WHFB-FM is the latest to re-introduce the popular "Tell Me, Doctor" radio series to its listeners. Although no new recordings are being made of the program, all the records are filed in the MSMS office at Lansing for distribution to Michigan radio stations. County Medical Societies are urged to contact radio stations in their areas and offer the recordings.

* * *

There's still time to book the newest MSMS exhibit for county fairs and other summer festivals in your area. The exhibit is self-contained in one unit and shows motion pictures. It occupies a 3 x 10 space.

* * *

The MSMS Television Committee is considering a plan of distribution for the five-minute slide films to be offered to TV stations in Michigan this fall. The slide films will cover a variety of subjects both scientific and socio-economic.

Editorial Comment

"I'M TOO BUSY"

Anyone who participates in voluntary organizational work in our profession soon finds himself particularly obstructed by the above phrase. This is particularly evident when he attempts to solicit the efforts of others. Paradoxically, it is almost axiomatic that if you want to get a job done, pick on the busiest man you know and he'll do it!

We made a personal survey of several general practitioners who everyone knows are busy men, darned busy. We asked each of these practitioners. in separate conversations, a few leading questions. For instance, "Do you ever get time to attend church? What about going to a show? Do you have time to play golf, bridge, poker? What hobbies do you have and do you have time to follow them?" These questions lead to the following conclusion: Everyone actually "has the time," if he just wants to do something bad enough!

Obviously, there are some few "sorry" days in any physician's routine, where extraordinary or unusual circumstances arise. These absolutely preclude stopping "to have a Coke" or any other such activity, usually meaning from fifteen to thirty minutes up to an hour, in just plain "chewing the fat." When a fellow is tired, perhaps has been up most of the night, it's difficult, almost impossible, to settle down for any constructive effort mentally or physically. He doesn't want to think, study or write. He just wants to sit!

Whenever we hear a colleague tell about some comedian, "I heard last night on the Blah-Blah Hour, and, boy, was he a riot," just watch out The phone will ring, and you'll hear that same guy say, "No, Mrs. Jones, I just haven't had time to phone in that prescription to the druggist for your boy. You know there's a flu epidemic going on, and all of us doctors are just worked to death. So I just haven't had time. I've been too busy . . ." Oh, yeah?—Editorial, *J. Missouri M. A.*, May, 1953.

SECOND LOOK AT SOCIALIZATION

Those who believed the operation of last November 4, wrote finis on efforts to combat the malignancy of socialization in this country should follow the precedent of several well-known surgeons and open up for a second look. Reports from the laboratory may seem quite satisfactory but careful exploration reveals much evidence of disease.

From the Superintendent of Documents, Government Printing Office, may be obtained a volume, Financing Social Security. Price is one dollar. It was written by Ida C. Merriam, of the Division of Research and Statistics of the Federal Security Agency. This is the division headed by I. S. Falk who has spent his life promoting various schemes of socialization, particularly those involving medicine.

Philosophy of the publication, undoubtedly determined by Falk, is shown in one revealing statement. There are others but this one should be sufficient:

"The extent of the shift in income distribution will be greater if—as is quite generally true in social insurance programs—the benefits, in relation to previous earnings and contributions, are proportionately higher for low—than for the higher —income earners. The effect on the distribution will also be greater to the extent that contributions used to finance benefits come in relatively larger measure from the higher-income groups."

This was not written by Karl Marx. It was written by a federal employe whose salary is paid from taxes. She and her superior, Falk, are still employed by the federal government. They will hold their jobs because they come under Civil Service. They will continue to produce this kind of material, to be published by the Government Printing Office.

Perhaps those who devised the second look operation developed an idea which can be applied to more than one kind of malignancy.—Editorial, *Northwest Medicine*, May, 1953.

PHYSICIANS ASSIST MEDICAL EDUCATION

More than $3,150,000 for direct support of medical education was given in 1952, by some 37,000 doctors in the United States, says Dr. Donald G. Anderson, secretary of the American Medical Association's Council on Medical Education and Hospitals. And that amount is exclusive of sums given for buildings, endowments, scholarships, research, and other special purposes.

In addition, reports from seventy-six of the seventy-nine medical schools throughout the country show that more than 29,000 doctors contributed a further $2,258,534 directly to the teaching budgets of those institutions.—Editorial, *The American Academy of General Practice*, May, 1953.

* * *

A diagnosis of cancer may provoke a tempest of despair which often proves overwhelming to the patient and his family.

* * *

Despite monumental efforts to stress hope and emphaize successful results for cancer patients, most lay persons still regard a diagnosis of cancer as a death sentence.

The JOURNAL

of the Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOLUME 52 JULY, 1953 NUMBER 7

The Adenoid Problem

By Ben H. Senturia, M.D.
St. Louis, Missouri

MANY discussions have appeared in the lay and medical press regarding the indications for tonsillectomy and adenoidectomy. This morning I would like to direct your attention to the possibility that we should be doing more and better adenoidectomies.

The introduction of chemotherapeutic agents and antibiotics has made possible the prompt control of most nose and throat diseases and hence a lowered incidence of middle ear and mastoid infections. However, there has been considerable discussion, recently, in the otologic literature regarding the apparent increase in the incidence of middle ear effusions and the increasing number of hearing problems.

On first examination these several observations appear unrelated, but on closer inspection, these problems, (1) the widespread use of antibiotics to control ear, nose and throat diseases, (2) the high incidence of middle ear effusions, and (3) the increased number of hearing problems, may have as a common denominator the adenoid problem.

More patients, especially children, are being referred to the otolaryngologist with symptoms which appear to be a result of hyperplasia or infection of the adenoid. These symptoms include difficulty in hearing, persistent nasal congestion, postnasal drainage, constant clearing of the throat, gagging and coughing. The history is remarkably consistent. The patient reports that he developed an upper respiratory infection and was seen by his physician. A diagnosis of tonsillitis or respiratory infection was made. One of the sulfonamides or an antibiotic was prescribed.

The patient's febrile reaction was controlled promptly. Any tonsillitis present cleared in a matter of a few days. Although the patient was not entirely well, for one reason or another the expensive drugs were stopped. This abrupt cessation of therapy occurred despite the persistence of nasal congestion, postnasal drainage, a nagging cough and a stuffy feeling in the ears.

At this point, the patient called his physician and was told that he had better see his Ear, Nose and Throat specialist, or, as was frequently the case, decided on his own to make an appointment with the otolaryngologist.

What does the specialist observe in such a situation? Since children constitute the largest percentage of these cases, let us describe the otorhinological findings in a typical child.

Case 1.—Johnny is five years old, healthy and well nourished but looks the worse for several restless nights. The temperature is not elevated.

Ears: The ear canals are clear but ear drums are full and reddened or dull brown and retracted, and there is fluid visible in the middle ears. Hearing is obviously decreased.

Nose: The nasal mucous membranes are reddened and the turbinates congested. Mucopurulent secretion is present in each nasal fossa. Fair shrinkage of the turbinates is obtained within five minutes after the instillation of nose drops. Through the nasal fossae the adenoid mass may be seen obstructing the posterior nares and the upward movement of the soft palate is impeded by the adenoid. The surface of the adenoid is fiery red and numerous small hemorrhagic punctate areas are observed. A small amount of thick mucoid secretion can

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Presented before the general assembly of the Michigan State Medical Society, Detroit, Michigan, September 25, 1952.

From the Department of Otolaryngology, Washington University School of Medicine, and the Department of Otolaryngology, Jewish Hospital, St. Louis, Missouri.

This study was assisted by a grant from the St. Louis Otological Foundation.

be noted adhering to the upper surface of the soft palate.

Throat: The mouth cavity is clean. The tonsils are only slightly enlarged and are somewhat reddened and there is increased peritonsillar injection. The crypts contain a small amount of cheesy debris. The posterior oropharyngeal wall is covered with multiple, reddened, granular follicles and the lateral bands are reddened and hyperplastic and extend superiorly as far as they can be visualized up into the nasopharynx. A small amount of mucopus can be observed adhering to the posterior wall of the oro-pharynx.

Neck: There are numerous posterior triangle nodes and slightly tender movable jugulo-digastric nodes.

How shall we interpret these findings? What has transpired in the upper respiratory tract to cause this clinical picture? More specifically, what histopathologic and bacteriologic transformation has occurred in this area? In order to better appreciate the changes, let us review briefly some basic embryology and anatomy.

The adenoid first appears as a subepithelial infiltration of lymphocytes at the third to fifth month of intrauterine life.[1,2] By birth it has grown rapidly as a result of the development of germinal centers. Within a few months after birth, the dense fibrous base on which the adenoid rests has sent out trabeculae containing blood vessels, nerves and lymph vessels to each lobule. As it develops, it becomes a lobulated organ arranged rather regularly about a central depression. The surface is thrown into folds and deep furrows into the base of which open numerous glands.[2]

This main adenoid mass is centered on the posterior pharyngeal wall[5] but frequently appears to extend onto the roof of the nasopharynx.[11] Often its lymphoid elements on the roof are indistinguishable from the main adenoid mass. In fact, there are numerous elevations in the nasopharyngeal mucous membrane produced by underlying collections of lymphocytes (lymph nodules) which are believed to have the same function as the larger masses found in the adenoid or tonsils.[16] These may increase in size along with the adenoid mass to overgrow the Eustachian orifice and obstruct the posterior nares.

The adenoid with its peculiar distribution of folds and deep-lying crypts offers a unique site for the development of acute and chronic infections, a site where organisms may grow and develop a symbiosis with the tissues.[14] The normal flora usually consists of Streptococcus viridans and non-pathogenic Neisseria.[18] For some unexplained reason, the hemolytic streptococcus frequently appears in the nasopharynx during the winter and grows in profusion in the folds of the adenoids.[3]

In response to a bacterial attack there is a rapid increase in the volume of the lymphoid tissue making up the adenoids and pharyngeal nodules. This hyperplasia of lymphoid tissue occurs with dilatation of blood vessels and active migration of lymphocytes and neutrophiles into the epithelial covering,[14] thus producing the reddened, granular pharynx. The migrating cells combine with the desquamated cells, epithelium, and bacteria to form the follicular or membranous exudates which we see through the child's nose covering the folds or the "crypts" of the adenoid. As the process progresses, multiple small abscesses may form at the depths of the furrows. With each new infection more hyperplasia occurs, increasing the volume and size of the adenoid.

With continued insult the lymphoid nodules on the roof and lateral walls of the nasopharynx and on the tubal folds enter into the process of hyperplasia until we see a picture of diffuse overgrowth in the nasopharynx and then of obstruction of the posterior nares and of the pharyngeal ostia of the Eustachian tube. Thus the adenoid whose function was originally protective has now hyperplased until it is pathological. Its presence in the nasopharynx presents a mechanical obstruction which interferes with good ear and nasal function.

As a result of this obstruction, inadequate ventilation of the nose and interference with the normal nasal ciliary activity occurs. When this malfunction is combined with an acute nasopharyngeal infection, contamination of the nasal fossae results. We then observe increasing congestion of the mucous membrane and the turbinates, stagnation of secretion in the nasal fossa, obstruction of the sinus ostia, and finally a filling of the sinus cavities with purulent secretion.

The nose is only one of the contiguous structures to be contaminated. The mechanical interference with drainage from the Eustachian tube plus the subepithelial extension of the infection up the tube[6,8,17] results in an intense congestion of the epithelium along the entire Eustachian tube and middle ear, an infiltration with lymphocytes, and an outpouring of mucoid secretion into the lumen. Inability to ventilate the middle ear via the constricted Eustachian lumen results in a negative middle ear pressure (much as one gets on rapid descent in an aeroplane). If we now combine

acute inflammation plus negative pressure, we have the explanation for the outpouring of transudate or exudate, and thus the picture of middle ear effusion with its dull reddish brown, retracted ear drums. If the inflammatory response continues, a full red ear occurs. As a consequence the patient complains of "talking into a barrel," difficulty with hearing, dizziness, tinnitus, et cetera.

It is not enough that the adenoid has monopolized almost the entire nasopharynx. Now the purulent drainage from the nose stagnates along the superior surface of the soft palate and adheres to the surface of the irregularly shaped adenoid. As a consequence, all along the avenues of drainage, especially along the lateral bands and on the posterior pharyngeal wall, there are produced islands of lymphoid tissue. All of these nodules may contain infected crypts.

It is clear, then, that the cause of Johnny's persistent sequelae may lie within the nasopharynx. These sequelae have made it necessary for us to reacquaint ourselves with the anatomy and physiology of this area.

Because of the relatively small size of the bony cavity and the peculiar anatomy which is involved, it appears that infection and/or hyperplasia of the lymphoid tissue in the nasopharynx area may lead to a host of symptoms. The extent of the symptoms depends on the (1) original size and shape of the nasopharynx, (2) the size and distribution of the adenoids, as well as (3) the shape and position of the Eustachian orifice and its associated folds. With a view to understanding the symptoms and diseases evolving from changes occurring in the nasopharynx, let us review briefly the surgical anatomy of this area.

The nasopharynx is surrounded by a strong, fibrous aponeurosis, supported externally by the constrictor muscles.[5,20] During swallowing and gagging, the stylopharyngeal muscles pull the pharyngeal muscles superiorly. This is demonstrated when one tries to operate without a satisfactory depth of anesthesia and one is confronted by the horizontal fold of mucous membrane just above the level of the soft palate. It is this same mechanism which causes the thick, viscid, adherent secretion to be expressed from the nasopharynx into the oropharynx.

The widest part of the nasopharynx is almost entirely bony and not capable of much change in form. The anterior wall is formed by the two posterior nares with the posterior margin of the nasal septum between them. On the lateral wall one sees the pharyngeal ostium of the Eustachian tube with its associated cartilages and folds and the pharyngeal recess. I should like to focus your attention on these folds because we will refer to them as one reason for occasional failure of adenoidectomy.[15] These folds consist of the following:

(1) Salpingo-pharyngeal fold—from the inferior end of medial lamina to the pharynx.

(2) Salpingo-palatine fold—from the tip of the lateral lamina of the cartilage to the palate.

(3) Salpingo-nasal fold—from the superior margin of the tube to the roof of the nasopharynx.

Just posterior to the Eustachian tube, on the lateral wall, there is a deep triangular lateral extension of the nasopharynx which is termed the pharyngeal recess (Rosenmueller's fossae). This recess is usually lined or filled with lymphoid tissue which sometimes overflows onto the tubal cartilages, interfering with tubal ventilation and contributing to certain hearing problems to which we have referred.[20] In operating in this area it is well to keep in mind that its lateral wall is in close relation to the carotid artery.

The manner in which the posterior wall of the nasopharynx joins the roof of the nasopharynx is of surgical importance. Good visibility of the nasopharynx is influenced by the following anatomical facts. The roof is formed by the basilar part of the occiput and the body of the sphenoid. The posterior nasopharyngeal wall is composed of the atlas and axis. As you recall, the skull is almost immobile on the atlas. The atlas can only rotate on the axis. Therefore any flexion or extension of the head on the neck must occur at the junction of the axis and the third cervical vertebra.

For practical purposes we may describe three types of nasopharynx[7,15,19] depending on whether the posterior wall joins the roof as a continuous smooth arch or at an abrupt angle.

(1) Steeple type—a high narrow nasopharynx in which the roof joins the posterior wall at an obtuse angle—is most common in adults.

(2) Flat type—the roof and the posterior wall join at an angle of 90 degrees. This forms a deep nasopharynx and it is frequently difficult to reach the curtain of adenoid lying anteriorly on the roof.

(3) Sloping type—the roof is at the same level as the inferior turbinate producing a relatively flat elongated nasopharynx. This is the type which can be seen commonly in small children.

Fig. 1. Sideview of nasopharyngeal speculum showing long, flat angled handle to which is attached an inverted incomplete U-shaped tube. Note the absence of restricting walls.

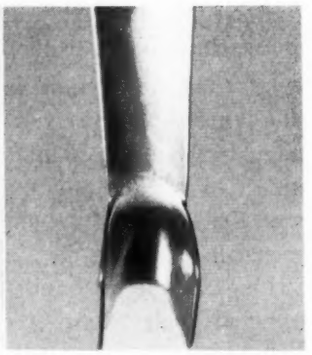

Fig. 2. Nasopharyngeal speculum viewed from above and showing excellent visibility.

These various types of nasopharynx introduce special problems in adenoid surgery. A routine adenoidectomy may be a simple and straightforward affair in that the main mass of adenoid tissue can be removed without difficulty from the posterior pharyngeal wall with the LaForce adenotome or curette. At least four problems, however, may complicate the routine procedure.

1. Adenoidectomy in the young infant. Consider the position of the adenoid in the young infant with severe nasal obstruction and consequent difficulty in feeding. The sloping type nasopharynx is tiny and shallow with a low lying roof, so that an adenoid no larger than the tip of the small finger will obstruct the posterior nares. You recall that the adenoid is well developed at three months. If the nasopharynx is small and the adenoid fills the cavity, we are frequently called on to clean out this obstructive mass in order to permit adequate nasal breathing and thus maintenance of the feeding program. Good general anesthesia providing complete relaxation of the constrictor muscle is essential for successful elimination of this type of adenoidal obstruction. If the curette is employed it must be used with care in the region of the pharyngeal orifice of the Eustachian tube. After use of the No. 0 LaForce adenotome we prefer direct visualization to ascertain that complete removal has been accomplished, since a small piece of remaining adenoid will interfere with good nasal airway and therefore vitiate the surgery.

2. Hyperplasia of lymphoid tissue on the roof of the flat type nasopharynx presents a difficult problem unless one can visualize this area and carefully nibble away the tissue with an instrument like the Meltzer forceps. It does little good to remove a handful of adenoid from the posterior wall of the nasopharynx and leave a curtain of tissue hanging from the roof obstructing the posterior nares. I do not think that it is possible to rub away this adenoid tissue with a gauze-covered finger. Furthermore the roof of the nasopharynx is a difficult site on which to use a curette effectively. Direct visualization with a speculum and a good light will enable one to see the residual adenoid and remove it with a small biting forceps.

3. Occasionally, a prominent pharyngeal tubercle will present almost an insurmountable obstacle if proper instruments are not available.[4] In this situation, unless a lateral x-ray of the nasopharynx has been taken preoperatively, one is suddenly confronted with the fact that the LaForce instrument rides on top of an osseous peak with unreachable adenoid tissue all around it. Only with a punch forceps and a good palate retractor or nasopharyngeal speculum can one adequately remove the obstructing lymphoid tissue.

4. In spite of a well done adenoidectomy and radiation therapy, one occasionally encounters persistent nasal obstruction and continued ear symptoms. This may be a result of hyperplasia of the salpingo-nasal and salpingo-palatine folds which in some cases may measure 10-15 mm. in width.[15]

You note that these folds extend from the tubal cartilage to the pharynx, palate and to the roof of the nasopharynx. Their distribution is such that when markedly enlarged they may completely obstruct the posterior nares. Under these circumstances the excess lymphoid tissue must be bitten away from the folds.[9] This can be done without too much difficulty and with little bleeding by direct vizualization.

Numerous instruments are available for visualizing the nasopharynx during adenoid surgery. I will only mention the basic work of Gyergyay[10] and Zollner.[21] Very satisfactory palate retractors were developed by Love,[13] Lathrop and Cottle. Gyergyay,[10] Yankauer,[20] and Kelly[12] developed tube or speculum-type instruments.

No one of these instruments has received very wide usage in the past. In recent years our attention has been directed towards an effort to develop an instrument which would be of simple construction, allow good visualization and permit sufficient space through which to operate.

With this in mind, a speculum was devised (Figs. 1 and 2) which we feel utilizes the good features of previous instruments and surmounts some of their objectionable characteristics. It is believed that this speculum will permit the surgeon to operate effectively with good reflected light and reach hitherto inaccessible areas of the nasopharynx. Through the speculum one may readily see the roof of the nasopharynx. In most patients it is an easy matter to visualize the Eustachian orifices and the pharyngeal recesses. It allows one to inspect carefully the bed of the removed adenoid and observe the usual sites of persistent bleeding. Of greatest importance, it allows for careful direct visual examination for residual adenoid tags.

In summary, then, it is felt that the nasopharynx and its contained adenoid tissue is a source of many of the persistent problems which the practitioner is called upon to treat. It is believed that the adenoid may become a potential source of infection and obstruction causing or contributing to nasal congestion, sinus infection, tympanitis, middle ear disease and deafness. For these reasons it is suggested that more and better adenoidectomies receive serious consideration.

A recently developed nasopharyngeal speculum is described which permits direct visualization of the less accessible portions of the nasopharynx. With the aid of such an instrument, it is possible to perform more thorough removal of lymphoid tissue in this area and to make direct examinations of the site of operation.

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A Program of Control and Treatment of Tuberculosis in a Mental Institution

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THE CARE of mental patients whose disease becomes complicated by the development of tuberculosis, has long been a serious problem. Mental disease, as well as tuberculosis, is chronic and may require long periods of specialized treatment and hospitalization. Lack of sufficient trained personnel, lack of funds, and over-crowded conditions in many of these hospitals have contributed to the difficulties and have increased the hazard of the spread of the infectious disease to one another and to employes.

Tuberculosis has long been rampant in mental hospitals and has been considered as an unfortunate complication about which very little could be done. However, over the years, the passive attitude toward such a complication has changed. Administrators have become aware that the problem is serious and that something has to be done about it. In the past, temporary measures were effected. Patients were literally "dumped" into wards, with no thought given to the status of the infectious disease. In some cases reasonably good nursing and custodial care was overbalanced by large doses of medical neglect.

Michigan prides itself on the type of care given inmates of tuberculosis sanatoria and its mental hospitals. Except for the work done at the Ionia State Hospital, as reported by Isbister et al, no well organized program for the care of tuberculosis in mental institutions has been developed. The problem has long been recognized as a special one at the Traverse City State Hospital. The development of a program of handling this problem at Traverse City will be described herein. The entire program could not have succeeded had not Dr. R. P. Sheets, Superintendent of the hospital, shown excellent insight into the problems involved. His understanding and co-operation made it possible to set up and organize the entire medical and surgical program.

Traverse City State Hospital is representative of other mental institutions in the state. It serves thirty-nine counties of the northern part of the lower peninsula. Since 1942 its capacity has increased from 2,470 to 2,900 beds, without concomitant increase in space. In 1939, Harry L. Weitz, M.D., roentgenologist; and a resident physician, Milton C. Baumann, M.D., with some experience in the handling of tuberculosis, inaugurated an efficient and effective program for the screening and control of tuberculosis. Admission films for all newly admitted patients became compulsory. A card file was set up in the x-ray department, listing all active and inactive cases of tuberculosis. Clinical and laboratory procedures were incorporated with clinical treatment. A follow-up "tickler" file was then set up in order to periodically follow and call in known and suspicious tuberculous patients for re-examination. The effects of this program were immediately recognized, as shown by a definite decrease in the number of cross infections and re-infections.

During the years June 20, 1939, to January 7, 1943, segregation of cases was made on the basis of clinical and x-ray findings. In order to facilitate the handling of tuberculous cases, the files for such cases were printed on red paper or cards. The entire hospital was informed of the significance of these cards, which followed the patient wherever he or she went.

In 1943, the institution was left without anyone particularly trained in tuberculosis treatment. Case recognition and segregation was maintained through the x-ray department. However, the active therapy program gradually depreciated. In 1945, and from 1949 to 1952, inclusive, the Michigan Department of Health has been making a yearly survey of the hospital population with the exception of those patients known to have pulmonary tuberculosis. Accurate records of the number of patients admitted to the tuberculosis ward are not available. However, since 1949, the number of cases has gradually decreased. In the 1952 survey 3,750 x-rays were taken of patients in the hospital, those on Family Care, and personnel. Only two cases of active tuberculosis were found; one in the hospital, and the other on Family Care. This deficient program remained in effect until October, 1950, when the writer, a clinician with experience in tuberculosis, was added to the staff.

The conditions in the wards used for the care of the tuberculous patients, was found to be far from ideal. The structure housing these patients was a long ward on the second floor of a two-story

building. The elevator shaft and stair entry separated the male and female sections. The treatment and dressing rooms were scantily equipped. Each side had seven single rooms, one large ward, one sun room and one combination sun room and ward, which housed a total of eighty-four male and female patients. Patients in the single rooms used stool chairs, while the rest were served by a combination room containing five toilet seats and three wash bowls. Shower baths were given twice weekly in a central shower room. The males were shaved twice weekly in the washroom. The food for the tuberculosis ward was cooked in the main kitchen and transported by food carts and served to the patients on trays. There was no active therapy. Protection to personnel was attained merely by the use of a mask and gowns. Patients requiring fluoroscopy or x-rays had to be transported by car or ambulance to the receiving building.

The initiation and administration of a program for the care of tuberculosis in the mentally ill presented many problems not encountered in a regular sanatorium. It took time to get oriented and to learn how to handle the different types of mental illness. All types and stages of mental disease and tuberculosis were encountered. Many of the ordinary basic principles of medical and hygienic management were impractical. Elastic procedures and regulations had to be improvised for the individual case.

Complete autonomy and control of the patients to be accepted into the tuberculosis ward was insisted upon. Because the wards were overcrowded, and because there were many patients with open tuberculosis, it was deemed essential that no new patients with inactive disease should be unduly exposed to infection or reinfection.

The nursing staff was indoctrinated into the objectives of the new program and instructed in the medical and hygienic management of the tuberculous patient. Since orthodox management was not possible, the doctor and the nursing staff agreed on modifications of the rules and regulations that were to be laid down. Sputum cups and tissues were impractical. Bed rest for the great majority was not attainable. Proper isolation and segregation of the far advanced cavitary tuberculous and the extremely disturbed was difficult because of the limited staff and the large wards. Intermingling of patients in the halls and in the wash and bath rooms was unavoidable.

Intensive laboratory and bacteriological studies were then begun on the doubtful cases. Except for the few more co-operative patients, sputum examinations were considered unreliable. A series of two or three gastric washings was done and sent to the state laboratory in Grand Rapids for culture and animal inoculation.

A new record system was set up and co-ordinated with the system in the x-ray department. The psychiatric behavior and record was reviewed with the course of the patient's tuberculosis. These data were correlated and a course of treatment determined. The cases fell into four broad classes: (1) Mild mental symptoms and arrested or inactive tuberculosis; (2) Arrested or inactive tuberculosis, but with such severe mental symptoms that it seemed unlikely that the patient could leave the hospital; (3) Active disease that seemed amenable to therapy and the possibility of having their sputum converted; and (4) Far advanced cavitary disease that precluded any effective treatment.

A plan of treatment was then outlined. A gradual plan of more effective isolation, as well as medical and hygienic management, was practiced on all. Group (1) cases with arrested tuberculosis and with mild mental disturbance were discharged. Group (2) cases were isolated. Group (3) active cases that were amenable to treatment were given streptomycin and Paraminosalicylic acid. The far advanced group (4) were isolated and treated with antibiotics palliatively.

A gradual but steady improvement was soon noticed. The attendants exhibited an intense interest in what and why things were done and were eager to report helpful observations on ward behavior. They took an increasing interest in individualized attention to patients. They felt more secure in knowing which of the patients were actively infectious; their work became more orderly, directive, and easier. Broad but flexible rules were drawn up regarding smoking habits, intermingling in the halls, isolation and bed rest.

The effects on the patients themselves were even more striking. Shock treatments and deep psychotherapy were not attempted. However, the fact that the patients were seeing a doctor regularly who seemed interested in their problems and was giving their physical ailments personal attention had a marked influence on their morale. Seeing some of their roommates go home, made an amazing change in their behavior. Instead of being resistive to treatment and generally restless, they were surprisingly co-operative and seemed to wel-

come attention. The tangible results of this program were revealing and gratifying.

The intensive bacteriological studies revealed the true status of the activity of their disease. Of the eighty-three patients that were classified as tuberculosis, forty-two were arrested or inactive; thirty-three showed positive sputums or gastrics; and eight were hopelessly far advanced. These figures changed from time to time, since there were a number of reinfections and reactivations due to improper isolation and overcrowding in the beginning. At the end of nine months, the census was reduced from eighty-three to seventy-two. There were nineteen deaths from tuberculosis and other causes. Two epileptics, transfers from Caro State Hospital, were found to be arrested and re-transferred. Six others, proven inactive or arrested, were sent home. Admissions to the tuberculosis ward were reduced because only proven active cases were accepted. There were thirteen new admissions during this period.

Although there was overall improvement in most cases under medical, psychiatric and chemotherapy management, it was apparent that further improvement could only be attained by integrating a surgical program. An agreement was entered into with Arthur L. Stanley, M.D., a thoracic surgeon, of Ingham Sanatorium, Lansing, Michigan. Arrangements were made whereby visits to the Traverse City State Hospital were to be made at regular intervals. At the time of each visit, the scheduled surgery was performed, cases under therapy reviewed, and future surgery decided upon. The Tuberculosis Control Officer, John Isbister, M.D., of the Michigan Department of Health was invited to participate in the program and to attend the therapy conferences.

The surgeon, the tuberculosis officer and the writer then reviewed most of the cases that might require collapse therapy and established the basic general plan of treatment. It was decided that pneumothorax was probably not applicable but that phrenic crush and pneumoperitoneum could be done as a preparatory procedure for subsequent surgery. Thoracoplasty and pulmonary resection were to be used when indicated. Bronchoscopy and bronchograms were performed for diagnostic purposes.

The physical facilities for this new venture were ideal. On the second floor of the Receiving Unit of the hospital is a modern, well equipped operating room, a complete x-ray department, and a six-bed isolation ward that lends itself to pre- and post-operative care of surgical patients. The laboratory and pharmacy are in the basement of this building.

A myriad of details had to be taken care of. A blood bank had to be established; instruments had to be purchased; a member of the hospital staff was trained in giving intratracheal positive pressure anesthesia; the operating room personnel was instructed in the technique of thoracic surgery; twenty-four-hour nursing service was provided in the isolation ward; and the attendants and doctors were instructed in pre- and post-operative care for the surgical patients; and two members of the staff were taught how to give pneumoperitoneum.

The first operative session was on August 16, 1950, at which time Dr. Stanley performed a first stage, three-rib thoracoplasty. A phrenic crush and initiation of a pneumoperitoneum was performed on two patients. Subsequent sessions were at two-week intervals, and on each occasion one or two major procedures were done along with phrenics or bronchoscopies. It was estimated that the main objectives would be reached in eighteen to twenty-four months, but the program proceeded so smoothly that at the end of nine months only a few treatable cases remained. The sessions could then be reduced to two-month intervals. At the end of a year no surgical cases remained except for newly admitted patients. Studies are now under way in order to determine which cases might need additional surgery.

Since the major objective was to eliminate positive sputums, a detailed report will not be given until more time has elapsed. At that time a statistical review will be made with case reports.

To date, eight thoracoplasties have been completed in nineteen separate procedures. One patient with a large cavity and a concomitant silicosis had to be abandoned after the first stage thoracoplasty because of a spread; a phrenic crush and pneumoperitoneum was substituted and he is doing well. This was the only spread of the entire group. Other complications were minor.

Five lobectomies for tuberculosis and one for cystic disease were done without a fatality or serious complication. The only death in the entire series was a severely deteriorated schizophrenic, who, while apparently recovering from a pulmonary decortication and lobectomy, died on the third post-operative day as the result of a cerebral embolus.

Sixteen patients were treated with a phrenic crush and pneumoperitoneum. Of this group, one died of a ruptured duodenal ulcer which had been present for many years, and another died from air embolism.

Even though it is early in the program, a few conclusions can be drawn at this time. The incidence of tuberculosis can be controlled and reduced to a minimum by compulsory admission chest films, yearly surveys of the patient population, and a careful follow up of suspicious cases. Furthermore, even without the complete thoracic surgery facilities, medical and surgical management of the disease can be developed to a point where it will closely approximate that of the most modern sanatoria.

The mentally ill tolerate surgery as well as, or better than, the mentally sound. In the beginning considerable thought was given to a consideration of the type and degree of psychosis that the patient had. Now, psychosis is not a factor in deciding if a given patient is suitable for surgery. All the patients were improved mentally and became very manageable. The severe psychotic patients have shown such phenomenal mental improvement that we welcome the opportunity to operate them. Detailed reports of some of these cases will be given in the subsequent report. The senile psychotics also do surprisingly well.

Two pints of blood are given for each stage of thoracoplasty, and two or three pints after a lobectomy. Two to three liters of intravenous fluids are given concomitantly. Mentally ill patients tolerate pain well, so that it is rarely necessary to administer analgesics after the second day. It is not uncommon for a patient to remark the day after a rib resection, "My arm is a little stiff today." Most patients are up the second or third day after surgery and are eating their full meals. No difficulty has been encountered in giving pneumo refills and all are more tractable than before.

The organization is not complete as yet and many refinements are lacking, especially in physiotherapy and rehabilitation. A more complete arrangement is necessary for specialized psychiatric therapy. There is no inactive ward, so that ground parole and graduated exercises are not possible except in those instances where patients are sent to work wards. Many of these difficulties will be solved when the new 100-bed tuberculosis unit is completed.

The above described regime is economically sound. The initial expense for equipment and training and organizing a team is largely taken care of by the savings made in those who are discharged to their homes. Treating and operating a backlog of cases that has accumulated over a period of years is initially costly. The sustaining program and the treatment of such patients in the early stages of their disease will result in a marked economy to the hospital and state. Our experience, so far, has convinced us that when the next report is made these preliminary conclusions will be verified. Expense can no longer be given as an excuse for neglecting the mentally ill who have developed tuberculosis.

Those in charge of mental health programs can establish a standard program for the control and care of tuberculosis in each hospital, under the direction of a roving phthisiologist, and send those that require specialized treatment to a center that has suitable facilities and an organized therapeutic team. Such an extension program is now being worked out with the Newberry State Hospital.

Medical Directors can no longer shirk their responsibility to offer the tuberculosis patient in the mental hospital humane, scientific, and efficient treatment.

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A DEFINITION

"The Doctor of Medicine is one whose training and outlook are predicated upon the acquisition and use of all available knowledge for the benefit of each individual patient. He makes no effort to lure people to his office. He and his *Profession* are completely responsible for what we know and do regarding sanitation, prevention of disease and public health.

"The cultist is one whose training and outlook are predicated upon some single, narrow, philosophic thesis or assumption. He fits each patient into his narrow band of knowledge and reasoning. He does his best to lure people into his office to increase his *Business*. He contributes nothing to sanitation, preventive medicine, or public health."

SAMUEL W. HARTWELL, M.D., Muskegon

The Scope of Public Health

By Gaylord W. Anderson, M.D., Dr. P. H.

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THE INVITATION to speak before this medical society affords an opportunity to discuss a matter of mutual interest, the question of the scope of public health. This is a matter of constant concern to the physician and public health worker alike. It is not a new matter for we have been discussing it for about a century and, I trust, it will still be discussed for many centuries long after all of us here have faded into the dim memory of the past.

Throughout the history of public health this discussion has brought out two rather distinct schools of thought. The conservative school has had its sincere doubts as to the wisdom of newer developments and the desirability of expansion of the scope of the public health program. At times it has viewed such expansion as the introduction of a philosophy contrary to our traditional way of life and has even raised suspicions as to the basic purposes and intent of those who favored expansion. The progressive school of thought, on the contrary, has advocated new programs of health protection and has often portrayed the conservatives as attempting to stifle progress and trying to preserve the *status quo*. At times it has even viewed the conservatives as motivated too much by self interests and too little by concern for the general public.

These differences of opinion are healthy for they promote discussion. When discussion ceases so does progress. It is unfortunate, however, that too often this discussion has been punctuated by vilification and invectives, which have cast suspicion on fundamental loyalties, personal motives and even upon ancestry. When such discussions are dragged into the political gutter we sacrifice our professional good name and standing and intelligent progress is replaced by mud-slinging which hurts everyone and benefits none. As a physician who has devoted his professional life to public health and who intends to devote the remainder of his life to this same purpose, I recognize that medical practice and public health have a common goal—the welfare of mankind—and I firmly believe that as educated and intelligent human beings we can and should discuss our mutual problems with complete freedom and with complete respect for the motives and integrity of each other. It is with this thought in mind that I should like to discuss this morning the scope of public health as seen by a public health worker.

The need for such a discussion is pointed up by certain trends and events of recent years. On the one hand we have seen the development of public health programs directed at the problems of the degenerative diseases. Many health departments have evolved programs directed at reduction of the high death rate from cancer which we all recognize as one of our leading causes of death. Such programs have often included provision of facilities for diagnosis and treatment. The case-finding concept has been extended in some places to include multiphasic screening programs whereby a supposedly healthy population might be screened for many other types of degenerative conditions. Through such screening unsuspected cases have been found that can be referred to their family physician for proper care. Such programs have been defended as an expression of the health department's obligation to protect the public through attack upon the most important causes of sickness and death—a marshalling of community resources to prevent or postpone physical incapacity and death.

In contrast to this movement, which is an expansion of the scope of public health programs, is the Cline resolution which was adopted at the meeting of the American Medical Association in San Francisco in June 1950 and, by failure of the House of Delegates to make modification as suggested by President Elmer Henderson, essentially reaffirmed in Cleveland that fall. This resolution expressed the conviction that health departments should limit their programs to collection of vital statistics, regulation of the environment, health education, control of communicable diseases, and provision of such laboratory and clinical services as are essential to the effective control of these diseases. The resolution expressly states that other diagnostic and therapeutic services should not be included in the public health program. It thus wipes out the programs for maternal and child health, crippled children, conservation of sight and hearing, school medical and dental services, de-

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generative diseases and mental hygiene. To the extent that it would turn the pages of public health backward a half century, this resolution is a striking example of the conservative point of view in contrast to the views of those who are seeking ways whereby the people, thru their health departments, may find means to reduce the toll from diseases that today constitute the principal causes of death. This resolution, which stands as the official opinion of organized medicine, properly raises again the question as to the scope of public health. To answer this question let us examine the evolution of our present-day public health program.

The primary purpose of and the only excuse for an organized government is the protection of the welfare of its citizens. Whether the factors against which protection is needed be an invading enemy, internal rebellion, fire, famine, or disease, government has in each instance a responsibility that it cannot avoid. This concept has been recognized for centuries and is inherent in our social structure. It has guided all of our community thinking whether in the field of education, commerce, safety or health. The importance of health as one of the community's most valuable assets is equally well recognized. In the middle of the last century Disraeli, that great leader of a capitalistic era, gave emphasis to this concept in the statement that "public health is the foundation upon which rests the happiness of the people and the power of the State. The first duty of a statesman is the care of the public health."

In its earliest form this governmental duty found expression in the many prohibitions that were enacted. Some of these appear to us as rather fantastic attempts to prevent the plagues and pestilences that were the principal public health problems of that day. Yet these enactments placed on firm foundations the concept that the people as a whole have the right to adopt those measures which are necessary for their own protection.

About the middle of the last century there evolved a new orientation toward public responsibility for health that has guided much of our subsequent thinking. When Edwin Chadwick was made secretary of the board to administer the Poor Laws in England he was impressed with the vast sums of money that were being spent to care for those who were incapacitated or left destitute by the ravages of illness that might have been prevented. He naturally inquired if it might not be more logical to finance a program of prevention than to wait until illness had developed and then pour out greater sums for the care of conditions that might have been but were not avoided. If a family is left destitute because of the death of the wage earner, the community must support the dependents. Chadwick postulated, therefore, a responsibility of government for the health of its people, that, if properly performed, would reduce the outlay in grants for welfare aid.

This was not the reasoning of a rattle-brained reformer bent on socialistic experiment and governmental usurpation of all personal rights and prerogatives. It did not come out of any communistic or totalitarian state. It evolved about a century ago in a country that was at the peak of its capitalistic development. It was a concept of pounds and shillings, not of intangible speculation as to human rights to a sound body and a sound mind. If this somewhat mercenary type of reasoning is tempered with humanitarian concepts, we have a philosophy of public health that is of very broad appeal to all classes of society. It is a concept of governmental right and duty to carry out those measures that will reduce both the incidence and unfortunate consequences of illness.

In order to carry out these tasks of protecting the health of the people, a new governmental agency was created, the health department or board. To this agency was entrusted the responsibility of protecting the people against all sources of illness and causes of death. The acts creating these boards gave no suggestion that their activities were to be confined to any narrow segment of the health needs of the people. The act establishing the first state health department in this country, the Massachusetts act of 1869, ordered the department to "take cognizance of the interests of health and life among the citizens." This phrase has been copied either verbatim or in slightly modified form into the health laws of almost every state in the Union. It is a mandate from the people that their legally constituted officials shall do what is necessary to reduce the toll of sickness and of death, and shall carry out a program to prolong efficient human life. There is nothing in this mandate, either specifically stated or implied, that would suggest that the health department should restrict its activities to a certain group of conditions and should at the same time deliberately ignore other important causes of illness and of death.

In the early days sanitation and communicable disease control became the foundations of public health programs because they presented the most urgent and most immediate problems. Filth was then the everyday companion of mankind and infection was rampant. The country was repeatedly swept by waves of smallpox and cholera in comparison with which the 1918 influenza epidemic shrinks into insignificance. Tuberculosis was truly the "captain of the men of death," malaria was widespread even where we now stand and diphtheria was wiping out entire families of children. It was logical, therefore, that the people through their health departments, should have directed first attention to such problems, not because there was any implication that these were to be the be-all and end-all of public health but because these problems were the most urgent.

Yet we recognize that programs to this end did not go unchallenged. The right of the people through their health departments to regulate the environment was repeatedly challenged in the courts, but the people were upheld. Public water supplies and sewage disposal facilities were attacked as socialistic programs which competed unfairly with the private water and sewer companies. When the late Hermann Biggs, then health officer of New York City, proposed the reporting of tuberculosis, he was bitterly castigated by medical societies for his so-called "effrontery" which was viewed as a violation of the profession's right of privileged communication. The construction of public hospitals for the care of the tuberculous was viewed with alarm as an improper governmental activity, and clinics for diphtheria immunization and smallpox vaccination were later challenged as beyond the proper sphere of public health. Step by step measures that we accept today as essential components of our sanitation and communicable disease programs have been challenged by those who feared such activities were beyond the proper scope of public health. Yet they were in all instances merely the fulfillment of the mandate from the people to take such steps as will provide protection from needless illness and death. The health officer could not be faithful to his oath of office if he failed to live up to this mandate from the people to take cognizance of their interests of health and life.

The development of the program for maternal and child health was likewise characterized by differences of opinion as to the proper scope of public health. Many felt that pregnancy was so personal a problem and child health was so much a matter of parental responsibility that they were beyond the scope of government and not matters of public concern. But the people quite obviously felt otherwise. When the United States Public Health Service failed to show proper interest in this field and chose to restrict its activities to what was then the classic field of public health, the Congress established such a program within the Children's Bureau some forty years ago. This act of the Congress was not the expression of some foreign idealism or of any new radicalism of the present day. Rather was it the voice of the people demanding that public health broaden its program to concern itself with the interests of health and life among the mothers and children, regardless of whether these interests were or were not related to the environment and communicable diseases. There was nothing new introduced into the basic concept of public health, merely a shift in program to meet the changing needs of society.

Today public health is in the midst of an expansion into the field of degenerative diseases. The Cline resolution to which I have referred is merely one of the most recent and most sweeping expressions of the inevitable and healthy criticisms of any new movement. It is not, however, the first and I doubt if it will be the last. It can be very simply argued that we do not know how to prevent the degenerative diseases, that there is no evidence of communicability or an important relationship to environment and that therefore these diseases are not within the province of public health. It can be argued that our only known attack upon these conditions is through diagnosis and treatment and that these latter are beyond the scope of public health. Yet the people have spoken otherwise.

In 1926, the Massachusetts legislature ordered the health department to study cancer as a public health problem and to bring in a positive program for attack upon this disease. The department reported that cancer was essentially a personal and not a public problem and not within the scope of public health. The legislature, angered by this failure to produce a constructive program, ordered the health department to establish and maintain clinics and a hospital for the diagnosis and treatment of cancer. When the medical society opposed such a program, the legislature further ordered the department to operate such

clinics "with or without the co-operation of the local physicians."

As a physician I deplore such legislation as an effront to the profession of which I am proud to be a member. Yet as one who believes that democracy has its foundation in the supreme right of the people to protect themselves as they see fit, I see in this legislation a clear-cut statement of the people that they believe that public health is not limited in its scope to any narrow confines but that it includes the degenerative as well as the communicable diseases. Only a few years later the same idea was expressed in slightly different fashion with the enactment of the first federal cancer legislation. This made legislative history in that for the first time in the history of this nation every United States senator affixed his name in advance as a petitioner for the legislation. Again, and on a national level, the people spoke and said very clearly that public health is not narrow in its scope but must be broadened out to direct its attack upon any important cause of illness and of death.

I realize full well that some will see in such a concept the influence of what they consider to be radical—and even alien—social and political philosophies. To the extent that one party has been in power for some twenty years and that those years have seen a rapid growth in the scope of public health, some may see the expression of a political philosophy with which they do not agree. To these may I point out that the Children's Bureau was ardently championed by Theodore Roosevelt and established under the Taft administration. The Shepard-Towner maternal and child health act was passed under the Harding administration. May I further point out that the Massachusetts legislature to which I referred was under strong Republican domination and the bill signed by one of the most conservative Republican governors of the present century. The National Cancer Act had the petitioning signatures of Democrats and Republicans alike. No, this is not partisan legislation, it is not the expression of a new radical, social or political philosophy, it is not an insidious attack upon our democracy by some foreign "ism." It is the voice of the people, regardless of political philosophies, giving new expression to ideas formulated a century ago. It is the people setting forth their right to take action collectively against the ravages and waste of ill health.

What, then, is the scope of public health? Can we define it in somewhat narrow and constrictive terms? I do not believe so. Public health has been given a clear mandate from the people that "it shall take cognizance of the interests of health and life among the citizens." We have long debated the meaning and proper interpretation of this mandate. When we were in doubt the people have interpreted it for us and given it new breadth. They have said clearly that "take cognizance" does not mean passively sitting on the sidelines deploring the loss of human life and tabulating those factors that contribute to such loss. The people have demanded a constructive program of action. At the same time they have said that "the interests of health and life" include all causes that shorten efficient human life, that public health shall concern itself as much with cancer as with cholera. They have given public health a clear mandate of broad public responsibility.

If we must define the scope of public health we may say that it encompasses those measures which people may take collectively to prolong efficient human life. Public health is the tangible expression of the people's right to provide for their interests of health and life. As such it must follow the expressed mandate of the people. If it is loyal to its public trust, public health can follow no other course than to adjust its program to meet the most pressing of our current health problems, to make available to the public the great potential benefits that lie in the discoveries of medical and sanitary science. The scope of public health has grown and is still growing as problems change but there has been no change in the basic governing philosophy of public responsibility. This in turn rests upon the fundamental concept of democracy—a government of the people for the benefit of the people.

In the years that lie ahead, as in the present years, there are bound to be many differences of opinion. New programs will evolve and there will be critics of them. Such criticism will be healthy if it is constructive and is premised upon mutual respect for each other's sincerity, intelligence and integrity. The English have a phrase for the minority party—her Majesty's loyal opposition—a phrase that expresses the concept that the minority party is as essential a part of the government as is the majority and is of equal loyalty. I should like to think of a medical society, when it differs

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The Use of Oral Metrazol in Psychosis With Cerebral Arteriosclerosis

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FOR MANY years metrazol has been used as a convulsant in the treatment of schizophrenia and the affective psychoses, as a respiratory and cardiac stimulant, and as a diagnostic aid in electroencephalography. Recently, reports have been published indicating that it may be of therapeutic value as an analeptic agent in geriatrics. Chesrow, et al., reported on thirty-two patients who were bedridden and in whom generalized arteriosclerosis, associated with senility, made nursing care difficult. These patients were given oral metrazol, and it was concluded that a significant number of them showed improvement. Their study, however, was merely qualitative, and the criteria of improvement were based solely on clinical opinion.

It has been shown by Freyhan and associates that there is a considerable reduction in cerebral blood flow in arteriosclerotic psychosis. The role of anoxia in the production of mental symptoms such as confusion and emotional lability is becoming more and more recognized, as mentioned by Houston. Accordingly, it was felt that metrazol, (1) by stimulating the respiratory center would improve respiration; (2) it was felt that by its cardiac effect the general circulation would improve; (3) at the same time, the analeptic action of the drug by its cortical stimulation should produce an increased sense of well-being in these patients; and (4) finally, a number of investigators feel that metrazol dilates the cerebral vessels, particularly those of the pia; but these studies have, up to now, not been conclusive.

Metrazol, therefore, has a combination of effects: a stimulant of the cerebral cortex and the medullary centers, especially that of respiration, a possible dilator of the cerebral vessels and a direct tonic effect on the heart muscle with a resulant increase in cardiac output.

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Method of Study

A group of thirty patients was selected. These were all men, ranging in age from sixty-three to ninety-two, with an average age of seventy-seven. The diagnosis in all but one case was psychosis with cerebral arteriosclerosis. The remaining case was one of general paresis, and it was included because we wished to determine whether or not metrazol might have some effect on some of the symptoms produced by the syphilitic endarteritis of the brain. For the most part the patients were free of other diseases at the time therapy was begun, although a few diabetics were included and some of the patients had had episodes of congestive heart failure but were being adequately maintained on digitalis and mercurials. Their psychiatric symptoms varied greatly, in that some were severely deteriorated, while others showed only mild mental changes such as memory loss or confusion.

In an attempt to reduce this study as much as possible to a quantitative scale, a rating system was devised as follows:

Each patient was given a numerical rating, from 1 to 4, for each of the following thirteen points: appearance, personal habits, control of bowels and bladder, sociability towards staff, sociability towards patients, speech content, speech ability, confusion, delusions, hallucinations, appetite, eating habits, and sleeping habits. On the rating scale the number 1 represented relative normality, while number 4 indicated severe disturbance. Each of the above thirteen points was so rated, and these scores were totaled; thus, a score of 13 would indicate normality, while a score of 52 would indicate deterioration almost to a vegetative level.

In order to avoid bias, these ratings were made by ward personnel rather than by the individual physician, who contributed only a clinical opinion at the beginning and at the end of therapy. (Interestingly, it was noted at the end of the study that these clinical opinions coincided with the "scores" given by the personnel of the ward). Each patient was rated on all of the above thirteen points by five to seven of the psychiatric nurses and attendants. The averages of these ratings were considered the final score. The raters were given to understand that some of these patients were to receive placebos, although none actually did. This, we felt, offered a suitable control and again helped prevent bias or prejudice. In those patients who were accessible, psychological testing

TABLE I.

	Before	After		Before	After
Appearance	3.4	3.1	Confusion	3.0	2.4
Personal Habits	3.3	2.9	Delusions	2.0	2.1
Bowel and Bladder	3.0	2.7	Hallucinations	3.6	2.4
Sociability to Staff	3.6	2.2	Appetite	3.4	1.8
Sociability to Patients	4.0	3.8	Eating Habits	2.4	2.5
Speech Content	3.3	2.5	Sleeping Habits	2.1	1.3
Speech Ability	3.5	1.9	TOTAL	40.6	31.2

was done; the tests used were the Bender-Gestalt and the Memory test.

The patients were evaluated four times: at the beginning, in ten days, in twenty days, and at the end of thirty days. The scores thus accummulated were carefully analyzed and were considered reasonably accurate, unprejudiced reflections of the clinical status of the patients at any given time. Accordingly, changes in the scores indicated actual clinical changes, as will be illustrated in the following case history:

L. D., a seventy-two-year-old Polish man, was first admitted to the hospital on June 12, 1947, because of a suicidal attempt. At that time he appeared friendly and co-operative, but in spite of a language barrier it was noted that he was disoriented and confused. The diagnosis of psychosis with cerebral arteriosclerosis was made and the patient was committed. For about a month he continued to be fairly co-operative and was able to get about in his street clothes; but at the end of that time he became noisy, resistive and mute and refused to eat, although he remained tidy. He was given fourteen electroconvulsive treatments, improved markedly and was given a convalescent leave after four months of further hospitalization. He remained out of the hospital for almost two years, but on April 15, 1949, he was readmitted with similar complaints of depression, disorientation, confusion and preoccupation. He failed to improve and therefore was again given two shock treatments in July, 1950; but he became far more withdrawn, denudative, untidy, could not wear his own clothes and required a hospital gown. He remained unchanged and therefore in September of 1950, another series of electroshocks was administered without improvement. From that time on he continued to be immobile, mute, unresponsive, drooling, untidy. He had to be spoonfed and did not walk by himself.

At the time therapy with oral metrazol was begun, he constituted a rather difficult nursing problem. The general physical examination was negative and all laboratory studies were within normal limits.

The patient was given an initial dose of 3 gr. of metrazol four times daily, but after five days of this treatment he developed nausea and vomiting; the drug was discontinued for two days, was then resumed at the same level. Metrazol was continued at this dosage level until the end of the study. The most marked improvement was noted within the first ten days of treatment. During this time the patient, who had formerly remained slumped in his chair, began to sit up straight. He would answer questions asked by nurses and attendants and was no longer untidy. By the time therapy was ended, he was able to sit at a table with other patients and eat his meals by himself; he spontaneously walked alone to the bathroom; and he no longer drooled. The nursing problem had diminished considerably.

To illustrate the correlation between clinical improvement and the method of scoring, Table I is a record of this patient's scores.

Thus it is noted that the total score improved from 40.6 to 31.2, an improvement of about 23 per cent. This bears out the clinical opinion.

Dosage and Side Reactions

Metrazol was made available in 1½ grain tablets and patients were begun on doses of one tablet three times daily. This dose was gradually increased to a final dose of four tablets four times daily, unless side reactions occurred.

In nine of the 30 patients, side effects in the form of nausea and vomiting were noted. These were never serious and subsided when the drug was discontinued for two days; and when therapy was reinstituted at a lower dosage, they did not recur. Ordinarily, the symptoms subsided within eight hours of the last dose. As a general rule, in those patients who exhibited intolerance the level at which toxic symptoms were produced was about two tablets (3 gr.) three times daily. If the patients reached a dosage level beyond this point, toxic symptoms were rarely seen.

In those patients who had shown some evidence of toxicity, maintenance levels were established at a point just below that at which symptoms had occurred. In no case was there a recurrence of symptoms. In those patients who showed no toxic reactions, maintenance doses at the upper limits (as defined above) were given.

In one case, through an accident in the preparation of the medication, a rather large overdose (12 grains) was given. Within approximately one hour the patient had a mild convulsion, followed by

TABLE II.

Case	Score		Case	Score		Case	Score	
	Before	After		Before	After		Before	After
1.	23.2	21.1	11.	25.7	20.4	21.	Expired	
2.	33.8	31.4	12.	32.2	26.4	22.	27.9	21.0
3.	24.6	20.3	13.	27.5	22.6	23.	Expired	
4.	22.0	17.3	14.	26.1	20.4	24.	Expired	
5.	Expired		15.	46.0	35.7	25.	16.8	15.9
6.	40.6	31.2	16.	22.0	15.6	26.	Expired	
7.	32.1	28.6	17.	21.1	21.4	27.	23.1	20.0
8.	23.2	21.0	18.	34.1	40.4	28.	42.1	33.9
9.	20.0	16.1	19.	17.9	17.1	29.	29.8	23.8
10.	21.1	15.1	20.	28.9	24.4	30.	26.9	29.0

another, still milder, about thirty minutes later. These were readily controlled with barbiturates, and no additional effects were noted. The patient was not apparently harmed, and all subsequent laboratory studies, including electrocardiography, failed to show any changes. It may also be noted here that in those patients who showed some side effects, the physical examination and laboratory studies failed to reveal any significant changes.

Results

Clinically, approximately one half of the patients showed considerable improvement. Many had been irritable, feeding problems, asocial, disagreeable, untidy, and often semi-stuporous. In these cases the drug appeared to exert its most profound effect, inasmuch as many of the symptoms disappeared and the patients became much more tractable and easy to care for.

From the standpoint of scores, approximately 20 per cent of the patients showed considerable improvement, while some 40 per cent showed a moderate improvement. Of the remaining twelve patients, five showed no change, five expired, and two continued to deteriorate. One of these last two was the aforementioned paretic, and the other was a severe diabetic.

Psychological Tests

Psychological testing, as mentioned, was performed before and after therapy on those patients who were accessible to such testing. Severely deteriorated patients, obviously, could not be tested.

The results of these tests were equivocal—and showed no significant changes. However, it must be borne in mind that those patients who showed the most clinical improvement were those who were rather severely deteriorated and therefore not amenable to psychological tests. The non-deteriorated individuals showed but little objective clinical improvement, and this fact was reflected in the psychological tests.

Table II will indicate some of the changes in scores.

Summary

Thirty patients were given oral metrazol to determine what effect, if any, it had on cerebral function. Of these, twenty-nine were diagnosed as "psychosis with cerebral arteriosclerosis," and one was a general paretic. They were rated on a numerical scale by various different observers at specified times during the treatment, the average of whose observations was taken as the final score. It was found that in approximately 50 per cent of the patients moderate to marked improvement was noted, while the remainder either failed to improve or continued to deteriorate. Five of the patients in the group expired, but in no case could the deaths be attributed to metrazol, either directly or indirectly. The details of results are shown in accompanying tables.

Conclusions

On the basis of the findings in this group of patients, the following conclusions have been reached:

1. That oral metrazol has a definite place in the therapeutic armamentarium of the institutional psychiatrist.

2. That oral metrazol is probably most efficacious on the more deteriorated patients, having but little effect on others.

3. That oral metrazol has little effect on general paresis.

4. That there is no definite contraindication to its use.

5. That it achieves its maximum benefit in cases of psychosis due to cerebral arteriosclerosis.

6. That it takes full effect within about thirty to fifty days; if there is no effect within that time, none may be expected.

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Emotional Attitudes of the Adolescent

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IN RECENT years much attention has been directed to the emotional problems occurring at the extremes of life. The development of the specialties of pediatrics and geriatrics have to a great extent given impetus to many studies of the psychological processes involved in these two diverse age groups. As critical a period in the inner life of the individual is adolescence. This is a time of conflict and stress for the maturing personality. Indeed, the period of adolescence could well be a special field of study and practice. It demands certainly a solid comprehension of the fields of pediatrics, endocrinology, dermatology, internal medicine and other specialties with reflected problems in developmental psychology. Quite obviously this paper can only touch on other areas of medicine relating to this period. It will concern itself for the most part with the psychosocial problems faced by the adolescent.

The adolescent period is generally conceived as taking place during the "teen" years, from about the thirteenth to the nineteenth year. In actuality, its limit can be more accurately set as occurring from the twelfth to the twenty-first year; although even with this age span, it is quite possible that it may begin somewhat sooner and end somewhat later. Individual variations in emotional and physical development are invariably present. Because of the rapidity and sudden surges of growth during this period, stresses of both a physical and of an emotional character are frequently observed. Puberty, the forerunner of adolescence, brings on sudden physiological and psychological changes. The emotional nourishment as well as the intake of food of proper caloric value received during infancy and early childhood serve as the foundation for the future development of the individual. However, it is in adolescence that fruition of these two factors is first observed.

Definite physical changes take place during this period. In both sexes, the body lengthens, broadens, and becomes heavier. In boys, the chest becomes both deeper and wider, the shoulders expand, the musculature in the extremities develops greater strength, and the voice begins to change. The genitalia become larger. In the case of the girl, her figure assumes the softness and the contours associated with femininity; her hips widen, her breasts become round. The genital organs mature; glandular changes take place. She begins to menstruate. Pubic hair makes its appearance, secondary characteristics develop. In both sexes, surges of physical growth in size and weight occur quite rapidly.

The changes start somewhat earlier in girls than in boys. Initial pubertal differences may start at ten or eleven in some girls but then also may be delayed until fifteen or sixteen. In boys they usually begin between the ages of twelve to sixteen. It must be noted that there exist great individual differences. However, the girl usually begins a rapid growth and gain in weight at about eleven, and is taller and heavier than the boy at twelve or thirteen, and by the age of fifteen has reached full stature. The boy's spurt in height and weight is more likely to begin at about thirteen. It usually carries him past the girl at fourteen or fifteen, and he continues to gain height and considerable weight at seventeen.

Changes in personality and emotional attitudes are no less rapid during adolescence. It is this rapidity of growth itself that makes a marked impact upon both the boy and girl. It was only yesterday that they were children. It was only yesterday that they were almost completely dependent upon their parents for love, protection and guidance. Suddenly they are thrust into a world where they have the physical appearance of an adult yet for the most part retaining a child-like intellectual and emotional comprehension.

It is not a simple step to take the role of an adult in this confused world today. Many factors enter the life of young men and young women to modify their drive for independence. Marriage, for which they are biologically prepared quite early in life, is of economic necessity delayed. Responsibilities which would have been theirs in a simpler environment are not shouldered until later in life. Because of the peculiar socio-economic factors in which they live, a check is placed upon the spontaneous maturation process.

It is in adolescence, nevertheless, that a sudden deepening of comprehension occurs, and with it a host of feelings and desires to respond to the stimuli of the outside world. An insatiable desire for new experiences and adventures drives the adoles-

cent forward. Not only must he find out about things but he must also act. He must go out into the world of real people and establish himself there. It is a world waiting to be conquered, and to the adolescent, he is the one who thinks he can do it.

The boy must prove himself physically competent. He wants to assert his manhood by strength, speed, agility, and intellectual superiority. The girl wants to be lovely, graceful, and attractive. Both sexes feel the need to assert themselves. There is a desire and drive to rid themselves forever of the authority of the parents, and to think and act for themselves. Conflict and rebellion are part and parcel of straining to shake off the shackles of parental domination.

The urge toward becoming an adult, however, continually comes in conflict with an urge to remain a child. The result of this ambivalence is strain, tension, anxiety, and fear. The adolescent does not have the background of experience to give him perspective and ability to make sound judgments. He becomes easily disturbed by insignificant events and reacts out of all proportion to their significance.

Parents are frequently made apprehensive by this apparent instability of the adolescent and tend to increase their restrictions. Where during an earlier period they had gradually gained confidence in their child's judgment, now, during this period of turmoil become not without some justification unsure of this unpredictable person's capacity to evaluate situations. Hence a struggle begins between parent and child. The instability of the adolescent is the inevitable result of psychological confusion which resulted from the ramifications of the biological changes that occurred.

Frequently, the boy or girl tries to make his claim for independence against adult authority, and then hesitates and reverts to childish dependency. Doubts as to the strength and efficacy of his abilities present themselves. He longs to take part in social and community life, yet he shrinks from the responsibility of actually doing so. He doubts the world as he does himself. He loses his childish certainty. The old standards of value no longer hold. At times the sense of disillusionment seems almost overwhelming.

Variations in the development of adolescents, and in the mental, physical and social growth of the individual add still further to the conflict. A boy or girl who is either much taller and more mature looking than his friends or classmates or one who is shorter and more childish in appearance feels "queer" and "different." And often the one who is well developed physically may be immature emotionally. An adolescent who may mature physically very slowly might have the mental development of an adult.

This conflict, a normal accompaniment of adolescence, produces emotional disturbances which explain partially the behavior characteristics of this age period. The adolescent tends to be moody, vacillating, uncertain, unstable, introspective, and to go to extremes. Sometimes the struggle to free himself from emotional dependence leads him to show open hostility and to defy adult authority. Because he is most attached to his parents, and has depended upon them most completely, he may deliberately turn from them and seek counsel and advice from some other person outside the family. Often he idealizes this person as he idealized his childhood heroes. The adolescent may withdraw within himself and take refuge in daydreaming in which like in childhood he creates an ideal world.

Feeling sure of himself in one sphere of life, the adolescent may overemphasize that area and neglect other areas. Thus, he may overwork himself in school or devote himself wholly to sports or to social life. He may exaggerate his social responsibilities; he may overemphasize his importance to the school team; he may suffer great qualms of apprehension over grades in school. Yet, almost always he longs to be "like the rest," like the others of his own age group. He wants to look like them, dress like them, and behave like them.

Strain and tension are found among adolescents in homes of all income levels. They are found where family, school and neighborhood conditions are entirely favorable. Periods of social stress invariably aggravate them. Depressions, wars, and economic unrest make the problem of growth and development more hazardous. Pressures blocking independent behavior but not the urge to independence frequently intensify the strain and conflict. Normally unsure of his own competence and questioning the ethical standards with which he has been raised, the adolescent suffers still further from the loss of confidence in himself and society.

Normally the adolescent should feel from the time of birth the strong and abiding love of his parents. It is his mother and later his father who are the first persons he knows and on whom he is

dependent, whose love gives him faith in himself, and in the world, the faith which is the foundation of his security. When in infancy he gradually becomes aware of the difference between himself and other human beings, it is through returning his mother's love that his emotional drive begins to turn away from himself. It is because of his strong attachment to his parents that he gains a conception of the masculine and feminine roles, and consequently learns to play his own. Through identification with them, he sets standards of behavior and tries to live up to them.

The adolescent needs the opportunity to achieve, for achievement is a fundamental growth need. Born with an insatiable curiosity about the world and with an overflowing energy, he has an impelling urge to act in relation to that world and to master the problems of his environment. He will be able to achieve only if he is given an environment in which he can function; if the experiences have meaning for him; if he is allowed enough freedom to make his own adaptation to that environment, and is not compelled to conform to a rigid pattern of behavior. He needs also some kind of guidance which means assistance—not domination.

The child who has grown up in such a house and community where conditions are favorable will approach adolescence with an inner strength. Though he will be somewhat conflicted, anxious, and uncertain, he will be fortified both by his past achievements and by the fact that he has both given affection and received affection from others. He will not be too dismayed by the responsibilities of approaching adulthood since he has been accustomed to accept responsibility in proportion to his maturity. He will also be disciplined because he has learned to discipline himself, and to delay present gratification for future and more important ends, whose importance he could understand; to subordinate personal desires for the common good since his own interests have been identified with those of others.

Basically, the greatest need for the adolescent is that his parents should understand the nature of the struggle he is making and give him the right kind of assistance. It is necessary that they appreciate both his continued need for guidance and his urge to independence, and be ready to help him when he needs help, yet respecting the fact that he is increasingly trying to think and act like an adult. They should also understand and not criticize his idealism, his often groundless anxieties, his vacillations, and his sometimes bizarre behavior. They should respect his vocational choice even though it might not be their own. They must steadily encourage his attempts to become emotionally independent of them, through his widening social interests, through deepening attachments to other adults, and to other adolescents of his own and opposite sex.

Under these conditions, the adolescent can achieve maturity. When they are absent, when parents, themselves, who are immature seek personal fulfillment through their children, when they cling to them emotionally and exert pressure upon them to follow a course of behavior simply because it seems to them desirable, resisting their attempts to lead their own lives and choose their own friends—then adolescents have a difficult time in growing up. The result of this inability to make a satisfactory adjustment, is generally emotional disturbance. Just as rising temperature or pain are symptomatic of an unusual physical condition, so is the behavior of the adolescent symptomatic of personality disturbance. The individual responds in one of two ways depending on his nature.

If he feels he has the strength to do so, he stands his ground and opposes the environment; if he doubts his strength, he withdraws from it. Those adolescents who oppose the environment, openly defy adults, parents, and teachers. Others refuse to do their school work, truant, quarrel and fight with their brothers, sisters, and classmates or bully younger and weaker boys and girls. These adolescents are seeking to gain a false security in place of the real security which has been denied them. Since the world has seemed wholly unwilling to accord them love or attention or a chance to count, they are trying at least to force it to notice them by the trouble they cause. They are "getting even," trying to assert themselves against domination.

The adolescent who withdraws from the world may shrink into himself and be timid, cold or reserved. Or he may become what adults call "good," be polite, well behaved, or docilely obedient. Often these withdrawn individuals commit acts of surreptitious hostility against those frequently quite weaker than themselves. Sometimes these adolescents indulge in excessive daydreaming, attempting thorough exaggerated phantasies to create an environment which meets their great needs.

Though it may not be realized, these boys and girls are quite as disturbed as those who manifest their symptoms more openly, and are just as much in need of help.

To understand the sexual problems of this period it is necessary that the earlier sexual development of the child be studied. As the young child develops the capacity to deal with the frustrations of his environment, and to find relative security therein, he finds that his emotional energy is not completely expended in meeting his immediate needs. A reservoir of emotional energy remains which finds an outlet in a new capacity to love as well as to seek love. This love may turn in many directions. Because of the great scope of this subject, it will be dealt with more extensively in a forthcoming paper.

Emotional disturbances generally do not manifest themselves suddenly. Since the environments of home, school, and community have, as a rule, been long exerting pressures upon the boy or girl, he has usually presented difficulties much earlier, possibly even in infancy. These difficulties have simply increased with the added strain of adolescence. If he does not receive assistance, the behavior of the boy or girl will clearly reflect the gravity of his condition. The one who was aggressively hostile becomes openly and bitterly antagonistic. In some cases, hostility toward the authority of the adults and other parent figures becomes hostility against the constituted authority, the state.

Severe punishment and ostracism as methods of handling emotional disturbances have had a deleterious effect on both the adolescent and society. For the cause of the disturbance is a belief on the part of these boys and girls that the world is against them, and that they can find no place in it. They have no conception of the reason for this, but vaguely associate it with their own unworthiness. Though they appear to glory in their behavior, they secretly fear both it and society's attitude toward it. Thus to inflict further suffering and humiliation merely confirms them in their belief, and consequently aggravates the disorder and unsocial behavior.

Summary

The emotional problems and the emotional growth occurring during adolescence are closely related to the physical phenomena which occur during this period. Structures, both physiological and psychological, are at this time modified and with these changes a readjustment in personality takes place. Like most upheavals, these changes do not come about without confusion and conflict. Becoming an adult is a battle with much of the end result depending on the emotional ground work and preparation laid in infancy and early childhood.

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ORAL METRAZOL IN PSYCHOSIS

(Continued from Page 736)

7. That the actual effect on cerebral function, as measured by the existing psychological tests, is negligible in the non-deteriorated group who are accessible to testing.

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The Psychosomatic Approach to Convulsive Disorders

A Report From the Michigan Epilepsy Center

By H. Waldo Bird, M.D.; Z. Stephen Bohn, M.D.; Ruth V. Copeland, M.S.W.; A. J. Derbyshire, Ph.D.; Therese E. Kidder, M.S.S.A.; and Lurene Z. Warren, M.A.

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OVER THE past fifteen years, society has begun to look with quickened interest upon a group of its hitherto discarded members, the individuals with a convulsive disorder. Familiar in man's midst since history began, they had always been regarded as a largely hopeless proposition. A few had responded to the therapies of their day which often were more fanciful than scientifically meaningful. But in most cases, the ill-understood seizures which characterized the affliction clung stubbornly to their victims despite treatment.

Although the discovery of the newer anticonvulsant medications in the last two decades opened fresh treatment possibilities, the convulsive individual still occupies a unique and unenviable position among the sick. For example, the employment limitations enforced by the seizures are paradoxically severe as contrasted with many patients' capacities in the seizure-free intervals. This situation alone results in the development of a host of emotional and economic problems. The description of epilepsy as "the last of the hush-hush diseases"[4] dramatically emphasizes the severity of other social stresses upon the epileptic. In addition, the seizures themselves are manifestations of a most serious internal derangement, both in physiologic and psychologic functioning. Faced with this complex interplay of physical and emotional factors originating within and outside his convulsive patient, the physician finds it advantageous to utilize a "psychosomatic approach" in his evaluation and treatment.

The Study of the Whole Person

The psychosomatic approach is a point of view which stresses the fact that the patient with seizures is a total person in whom the functions of the body and of the mind are intimately interrelated. It denies that a patient is merely an efficient conglomerate of physical and emotional units. Indeed, the day has come when the "either-or" concept (either physical or mental disease) is rapidly being abandoned in the management of most illnesses. This holistic approach is indispensable whether it be followed by a single doctor in private practice, by a physician working with his consultants or by a team of specialists in the field of epilepsy. It is this whole epileptic person who is studied by the members of the professional team whose philosophy and method of operation form the basis of this paper.*

The keystones of the psychosomatic approach are the longitudinal and cross-sectional studies. The longitudinal study is a searching review of the patient's entire past life. Hereditary factors, illnesses, injuries, emotional experiences and attitudes, social influences and interpersonal relationships are documented as completely as possible. The patient is studied as a person who has lived in a particular culture, who was born of certain parents and who was reared in a specific constellation of relatives. The impact of physical and psychologic vicissitudes is observed and the after-effects traced in the structure and functioning of the mind and of the physical body.

The patient who presents himself with his symptoms and in his particular life situation is, in reality, ever changing. He is the result of all his earlier experiences up to the moment and is reacting constantly to external and internal influences as he moves forward into his future. Yet, he must be studied as he is in relation to, and as a product of, what he was. Therefore, a cross section of the individual in his present status is taken by the members of the team. An evaluation is made of emotional, social, physiologic and anatomic factors which have current effects on the patient. This data is correlated with the longitudinal study.

Role of Physiologic Medicine

When the psychosomatic approach is made by a team of specialists, it is ordinarily the task of the psychiatric social worker to obtain in its broad-

*The team at the Michigan Epilepsy Center is composed of the following staff members: a neurologist, neurosurgeon, psychiatrist, clinical psychologist, psychiatric social worker and electroencephalographer. When indicated, the assistance of an allergist, pediatrician and endocrinologist is enlisted although these specialists do not function as regular members of the team. The activities of the Center are supported jointly by the United Fund of Michigan and the State Department of Mental Health.

est outlines the historical data which form the basis for the longitudinal study. In certain areas, however, details are filled into the broad structure by colleagues. The neurologist, neurosurgeon and physiologist form the group responsible for the longitudinal and cross-sectional study of the somatic and neural aspects of the person from their genetic origin to their present status.

Throughout the routine of physical examinations and the laboratory studies, care is taken to note any particular interrelationships of factors characteristic of the individual patient. This is a physiologic study of the means by which disturbances in water balance,[5] acid-base balance,[9] carbohydrate metabolism[10] or blood calcium level[11] contribute epileptogenic forces to those generated by organic brain disorders such as diffuse or focal structural changes and variations in cerebral circulation.[13] Appropriate modifications in procedure can be made to study these factors. The electroencephalographic records may be taken under conditions of measured repose, sleep and activation. Specialized techniques such as pneumoencephalography, arteriography and electrocorticography may be employed. The results of the foregoing studies, viewed in the light of earlier hospital and doctors' reports, yield a dynamic picture of the physiologic forces which led to the symptom of seizures and of the changes in these forces brought about by growth and intercurrent diseases. Just as Bridge[3] so ably describes the physiology of the general group of people with seizures, so the team attempts to achieve this description for each patient.

It is a common observation that multiple pathologic factors in different organ systems exert a greater disruptive influence than when the pathology lies in one system alone. In fact, combinations of factors often lead to a single seizure in a person whose life otherwise has no obvious convulsive tendency. This is seen in the febrile convulsion occurring between ages one and three, a phenomenon often associated with a family history of seizures with high fevers. Here genetic trends cooperate with the effects of the physical illness in an incompletely developed brain.

The concept of a threshold for seizures has been used by many writers.[12] It is logical to assume that this threshold is present in every person and that it is partly established by genetic factors. Variations in psychologic and physiologic factors raise or lower the threshold from day to day. In addition, the forces which lead to seizure formation by means other than those which alter the threshold are also variable from day to day. The nature of the threshold is unknown. However, the team is strongly united in the belief that the seizure itself is a state of organic cerebral function potentially present in all human brains. This is illustrated by the production of seizures in all people by the passage of a sufficiently strong electrical current through the brain. This cerebral state may occur at any time and, in fact, can usher a person both into life and out of it.

The team is beginning to find in his physiologic patterns indications of emotional problems in the patient. His electroencephalogram, for example, may suggest trends for passive-dependent strivings. His visceral states may yield signs of anxiety. Even the type of seizure symptom itself may indicate certain personality trends. The patient with psychomotor seizures often shows a tendency to "act out" his conflicts rather than a need to attempt to solve them intrapsychically.

Role of Psychologic Medicine

As mentioned, the interview material obtained by the psychiatric social worker sketches in the longitudinal study. Since it is prepared for the use of representatives from several medical specialities, this history must have multiple foci. An initial evaluation of the epileptic's current status is provided by the worker who has a valuable opportunity to survey the patient in his immediate life setting. The degree of incapacity imposed by the illness and the patient's reaction to this burden are matters of concern throughout the worker's study.

To the review of the development of the patient, the clinical psychologist adds significant data and understanding. The psychologist supplements the findings of the other members of the team through the use of carefully scaled instruments which are used in standardized interviews. The projective techniques, which require that the patient react to unfamiliar stimuli, are especially sensitive. Psychometric testing provides information concerning the patient's present level of intellectual functioning to be compared with a former level. Evidences of conflicts which flourished at earlier stages of development of the personality can be detected, thus giving insight into the nature and significance of problems which are manifested currently. The psychologist is

often in a better position than his co-workers to establish the presence of certain organic defects of the central nervous system and can study the impact of these defects on the personality.[2]

In his evaluation of the convulsive person, the psychiatrist contributes to the longitudinal and cross-sectional studies by a clinical evaluation of the personality. This member of the team is especially interested in the nature of the character structure, in the interpersonal relationships, and in the presenting attitudes and specific problems of the patient. A search is made for emotional factors which may be important in the genesis of the convulsive disorder. The manner of expressing or inhibiting feelings and impulses, particularly those of a hostile nature, is noted. Further, the psychiatrist gives attention to traumatic childhood experiences (such as abandonment, witnessing of violent scenes, or loss of parents by desertion, death or suicide) which may be symbolically re-enacted in the convulsive phenomena proper.

Thus, from the correlated data obtained by the psychologist, psychiatric social worker, and psychiatrist, emerges a picture of the epileptic's psychic life. Attention is immediately drawn to the disrupting effects of the seizures themselves on the emotional adjustment of the patient. The prospect of undergoing a sudden loss of consciousness, accompanied by involuntary thrashing of the arms and legs, hoarse cry and uncontrollable seepage of urine and other body excretions, can hardly be faced with equanimity. A child must learn to control this kind of conduct in the process of his maturation. The reappearance of such behavior during a convulsion often provokes antagonistic feelings in the observers.

The specific emotional reactions of the epileptic to the manifestations of his illness are determined to a large extent by the personality structure of the person suffering the paroxysmal attack. He may, for example, sense the scorn of his associates and become ashamed. He may respond intuitively to their resentment with feelings of guilt. He may withdraw interest and attention from the outside world to be reinvested in himself. He may become anxious lest he express other aggressive feelings. Thus, the emotional problem with which the epileptic struggles is, in part, a "pathoneurosis."[7] This term describes the state of affairs where a physical disorder produces psychologic disturbances. But, on the other hand, psychologic factors may be the ultimate causative forces in seizure formation.

Most students of epilepsy seem to agree that their patients, by and large, are characteristically hostile and egocentric individuals. The convulsive person does not ordinarily form close relationships with other people and his attachments are not enduring. Very frequently he is beset by the urge to destroy and it has been suggested that the destructive impulses are repressed out of the fear of retaliation.[6]

Several authors have shown[1,6,8] that the seizure episode in the "essential" epileptic represents a sudden discharge of a mass of dammed-back affect in an individual with a physiologic predisposition for the convulsive pattern. Observations by the team in a wide variety of cases have led to the extension of this concept to all cases of convulsive disorder, whatever the origin. Examples are noted again and again in the histories given by relatives of convulsive individuals. They describe the patient's mounting tension, moodiness and irritability which warn the family of the imminence of a seizure. The ensuing episode may "clear the air" emotionally for varying periods of time. The release of the contained affect is accomplished in the explosive paroxysm. Isolated instances are known in which adequate seizure control has resulted in acute emotional disturbances. Return of seizures has been followed by an improved emotional state.

Synthesis

Although each member of the team approaches the convulsive patient as a total person throughout the study, his responsibility is discharged primarily in his own field of specialization. Integration of the study occurs in a formal staff conference. It is here that the physiologic and psychologic functions of the individual are considered to be merely two aspects of the fundamental biologic life process. Thus, the several descriptions of the patient merge into a composite, stereoscopic picture of the whole person. The interrelationships between all the epileptogenic forces noted in the longitudinal and cross-sectional studies become more clear. The role and purpose of seizures in the life of the individual person are better understood. He is no longer just another epileptic. The patient stands forth as a sick human being, a man, woman or child who has been forced to adopt the convulsive way of living.

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St. Luke's Hospital Clinico-Pathologic Conference

Edited by J. C. Smith, M.D.
Saginaw, Michigan

THE PATIENT was a white man, fifty-six years old, who was well until two years before admission to the hospital. At that time, he first noted back pain in the lower lumbar region that subsided after taping. The pain recurred and he sought osteopathic treatment. Since that time, the pain has always been present, although there were wide variations in severity. Two months before hospital admission, the back pain became severe and was associated with pain in the chest, neck, left hip, and across both shoulders. During this two-month period, there were also anorexia, a loss of 35 pounds weight, and a mild cough productive of yellow sputum.

The family history and review of systems were not contributory.

Physical examination revealed an emaciated, chronically ill, white male in whom the slightest motion caused acute back pain. The temperature was 98.0 degrees (F.), pulse 110, respirations 26, and blood pressure 138/88 mm. Hg. The head was not remarkable. The neck was supple and there was no enlargement of lymph nodes. Auscultation of the chest revealed loud inspiratory and expiratory wheezes in all parts. The heart was not enlarged, there were no murmurs, and the rhythm was normal. The abdomen was rounded and diffusely and slightly tender. The liver was palpated 3 cm. below the right costal margin. Other organs or masses were not felt. Rectal examination revealed a soft, symmetrical prostate of normal size. The external genitalia and extremities as well as the neurologic examination were normal.

The urine was clear, acid, and of specific gravity 1.022. Examination for Bence-Jones protein was negative. Hematologic examination revealed 7.6 grams of hemoglobin per 100 cc. There were 2,160,000 erythrocytes and 8,200 leukocytes. Differential count of 100 cells revealed 54 segmented granulocytes, 8 band cells, and 39 lymphocytes. The Kahn serologic test was negative. The serum phosphorus was 7 mg. per 100 cc. and the serum acid phosphatase was 1.5 Bodansky units. X-ray examinations were interpreted as showing a normal spine, pelvis, upper gastro-intestinal tract, and colon. Radiographic examination of the chest revealed soft tissue and calcific densities that were, at one time, stated to be suggestive of tuberculosis or histoplasmosis, and at a later time, stated to be not suggestive of those conditions but consistent with asthma. The tuberculin skin test was negative. Culture of sputum for Histoplasma capsulatum was negative after 7 days. Microscopic examination of stained sputum revealed no tumor cells. Examination of sternal bone marrow, done elsewhere, revealed 79 per cent lymphocytes, 11 per cent neutrophiles, 4 per cent blast cells, 3 per cent myelocytes, 2 per cent monocytes, and 1 per cent plasma cells. On the 18th hospital day, abdominal exploration was performed. This revealed a spleen that was estimated to be twice normal size, a slightly enlarged, smooth liver and enlargement and black discoloration of lymph nodes in the gastrohepatic ligament. Biopsy was taken of the liver and one lymph node. Histologic diagnoses included normal liver and chronic lymphadenitis with anthracotic pigmentation.

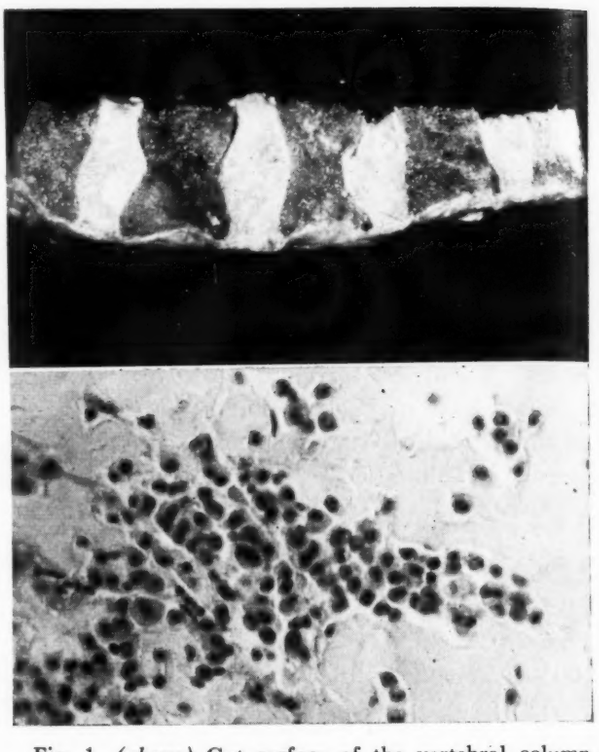

Fig. 1. *(above)* Cut surface of the vertebral column.
Fig. 2. *(below)* Microsection of bone marrow with rows of plasma cells embedded in amyloid.

The patient left the hospital on the forty-seventh hospital day and returned after two weeks. During that interval, x-rays taken elsewhere were stated to show destruction and compression of the sixth and twelfth thoracic and the first and second lumbar vertebrae. His condition, on re-admission, was unchanged except for acute pain over the right costovertebral angle. Biopsy of an inguinal lymph node revealed slight acute and chronic inflammation. The serum calcium and phosphorus were 15 and 4.75 mg. per 100 cc. The serum acid phosphatase was 6 King-Armstrong units. Bence-Jones protein was negative in the urine. The Congo-Red test revealed disappearance of 26 per cent in 1 hour and the dye was not found in the urine. The patient's condition became steadily worse and he died 35 days after the second hospital admission.

DR. GAMON: Now, I think this problem of making a diagnosis will be by a process of elimination. The patient was a white man of fifty-six years, sick two years with severe skeletal pain, loss of weight of approximately 35

Clinical discussion by A. E. Gamon, M.D.

pounds, and cough productive of yellow sputum. The x-ray report states that the lungs are consistent with asthma. The physical examination reveals an emaciated man with a rounded and slightly tender abdomen. The prostate was normal and biopsy of an inguinal lymph node revealed chronic inflammation. Laboratory examinations revealed a pronounced anemia and an elevated blood calcium and serum phosphorus. Toward the end of his hospital course, there was slight elevation of the serum acid phosphatase. It would be most helpful to have a report of his serum proteins and serum alkaline phosphatase as well. Urinalysis was normal and Bence-Jones protein was not found. The bone marrow differential count is most disturbing and I shall comment on that after the x-rays are demonstrated.

DR. CAUMARTIN: There are irregular calcified foci in both hilar regions that extend into the right base and represent calcified scarring, possibly from tuberculosis or previous fungus infection. These x-rays were taken about 6 months before his last admission and they reveal a normal lumbar spine and pelvis. Then here are radiographs of the spine and pelvis taken five months later and these reveal extensive and diffuse osteolysis of the spine but no sharply localized areas of bone destruction.

DR. GAMON: It appears here that we are dealing with a malignancy, the origin of which is to be determined. As the most apparent lesions are located in the bones of the spine, three conditions must be given particular attention. The first concerns soft tissue tumors that metastasize to bone, and these include carcinoma of the kidney, thyroid, prostate, and lung. Nowhere in the clinical record is there an indication of kidney or thyroid disease. Prostatic carcinoma must be considered as there was a slight elevation of serum acid phosphatase. However, the osteolytic x-ray appearance of the spine is not consistent with the characteristic osteoblastic type of prostatic metastases. I doubt that this slight serum acid phosphatase elevation is significant although it is known that prostatic malignancy with metastases occurs with a normal serum acid phosphatase. The x-ray appearance of the chest does not suggest bronchiogenic carcinoma and it is apparent that the main complaints were not related to the lungs. In addition, examination of the sputum revealed no tumor cells. Therefore, I shall overlook any of these sites as the probable origin of a malignant tumor in this case. The next consideration concerns malignant disease of the hematopoietic system. These include both lymphocytic leukemia and lymphosarcoma. The only lead indicating either of these conditions is the report of a lymphocytosis of the bone marrow. However, the retained structural pattern in the lymph node that was biopsied, the blood with normal differential counts, and the extensive lesions of the spine make these conditions, in my opinion, most unlikely. In addition, the bone lesions of lymphosarcoma are rarely so extensive or so clearly osteolytic. Therefore, I am reluctant to make a diagnosis of either lymphocytic leukemia, or lymphosarcoma. Lastly, there are the malignant tumors that arise primarily in bone. Paget's disease may be mentioned in this group only to be discarded because of the short history for that condition, the absence of pronounced osteosclerosis, and the serum calcium which is elevated. Osteogenic sarcoma should also be mentioned. However, this condition often affects patients in a younger age group, the bones of the extremities are usually the site of origin, and there is usually proliferation of bone rather than extensive osteolysis. Furthermore, metastases are usually widespread and particularly prominent in the lungs before the primary site reaches such extensive proportions. For these reasons, I am reasonably sure that this is not a case of osteogenic sarcoma.

We come now to multiple myeloma and there is a good deal of evidence in support of this diagnosis. The clinical picture is consistent, with prolonged back pain, loss of weight, and normocytic anemia in an elderly male. The laboratory supplies valuable evidence with increased serum calcium, an increased serum phosphorus and an elevation of serum acid phosphatase. It would be most helpful to have a plasma globulin and a serum alkaline phosphatase determination as there would be an expected elevation in both. The absence of Bence-Jones protein in no way excludes the diagnosis as this substance may be absent or only sporadically present. For this reason, several determinations should be made. Now it is true that the bone lesions of multiple myeloma are usually osteolytic, sharply circumscribed and multiple. However, the process may be osteolytic and of a diffuse nature. When that occurs, the spine is most frequently affected as in this case. Thus some of this evidence supports the diagnosis and all of it is consistent with multiple myeloma. Finally, we have a retention of only 26 per cent of the injected Congo-red dye. This, of course, does not exclude an associated amyloidosis; neither does it indicate its presence. I see no reason to think that there was complicating amyloid disease. Therefore, by a process of elimination, I arrive at the diagnosis of multiple myeloma, after consideration of the clinical, laboratory and radiologic evidence.

DR. J. C. SMITH: How is it that you make a diagnosis of multiple myeloma when the bone marrow report revealed a predominence of lymphocytes?

DR. A. E. GAMON: I have great difficulty in doing that. However, it is my opinion that the clinical and laboratory data are strongly suggestive of multiple myeloma and hence I reluctantly place less emphasis on that report.

DR. J. C. SMITH: Dr. Siler, we have a case here of severe bone pain, pronounced radiolucent changes in the spine, and an elevated serum acid phosphatase on one occasion. Isn't this consistent with carcinoma of the prostate with widespread metastases?

DR. D. E. SILER: Yes, it is. However, there are several points that do not exclude this diagnosis but make it unlikely. These include a soft prostate gland of normal size, an osteolytic instead of osteoblastic process in the spine, and only slight elevation of serum acid phosphatase that occurred late in the course of this man's illness. Furthermore, the chest x-rays reveal no metastases in the lungs although there is extensive involvement of the spine. These features make me believe that this condition is something other than carcinoma of the prostate.

DR. E. F. KICKHAM: I think sarcomatous degeneration of a Paget's disease of the spine should be considered. This is not uncommon.

DR. J. C. SMITH: Have you ever seen a case of Paget's disease of bone with sarcoma in which the malignant phase was not preceded by a period in which osteosclerosis was conspicuous?

DR. E. F. KICKHAM: No.

DR. J. C. SMITH: If there is no further discussion, we shall turn to the anatomic examination.

Dr. Gamon's Diagnosis

Multiple myeloma.

Anatomic Diagnoses

1. Plasma cell myeloma of bone marrow of vertebral column, ribs, and sternum, and of iliac, and mediastinal lymph nodes.

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Bon Secours Hospital Annual Clinic Day

June 9, 1953

ABSTRACTS OF PAPERS PRESENTED

Tetanus: An Unusual Case

D. N. SWEENY, M.D.

Uterine tetanus following abortion is now a well-established entity. Through 1950, there were 211 cases reported in the available literature with a mortality rate of 76 per cent. Considerable controversy exists as to whether hysterectomy should be done for postabortal tetanus. The case of a twenty-three-year-old criminally aborted patient who developed uterine tetanus is reported. The usual tetanus therapeutic regime was instituted including massive doses of antitoxin, antibiotics, sedation, and adequate nutritional maintenance. Hysterectomy was performed after no improvement was noted with conservative treatment. The patient recovered uneventfully following surgery. It is felt that hysterectomy is indicated in most cases of tetanus in which the uterus is proven to be the site of infection, provided the condition of the patient permits.

Recent Advances in the Understanding and Treatment of Shock

C. J. FRANCE, M.D.

Shock may be considered to be acute peripheral circulatory failure characterized by a disparity between the circulating blood volume and the capacity of the vascular bed. Shock may be induced by many different factors such as blood loss, trauma, bacterial toxins, dehydration, cardiac and pulmonary infarction, et cetera. Shock, once induced, may be sustained and intensified by secondary processes, and if untreated continue as a chain reaction until death ensues. The basic defect would appear to be anoxia which allows the release of vaso-depressing humoral and bacterial factors. Therapy is directed toward the prompt restitution of blood volume. Whole blood is by far the most effective agent due to the space-occupying function of the red cell as well as its oxygen carrying capacity. Plasma is also useful, the danger of serum hepatitis having been eliminated by the use of aged liquid plasma. Several plasma expanders have been developed in recent years which effectively increase plasma volume which may be used when blood is not available.

Gamma Globulin—It's Uses Today

I. F. BURTON, M.D.

Gamma globulin is produced by the fractionation of plasma proteins. It is almost in pure form and is about twenty-five times more active than that in normal plasma. It contains most, but not all, of the antibody fraction of plasma. Gamma globulin made from pooled plasma shows consistant titres to endemic virus diseases especially measles, infectious hepatitis and poliomyelitis. Its chief value is in the prophylaxis of these diseases. It is of little or no value in the treatment of the actual disease. Gamma globulin prepared from mumps convalescent serum (not the pooled plasma) is effective in the prophylaxis of mumps and the prevention of complications such as orchitis. Gamma globulin may be of value in German Measles. Its use in other virus diseases is as yet not established. The incidence of reactions is small and usually local. Serum hepatitis has not been reported following its use. Its protective action is of short duration lasting two to six weeks.

The Physician, Himself, as a Therapeutic Agent

H. H. SADLER, M.D.

The physician's attitudes, gestures, mannerisms and words sometimes profoundly influence his patients' health. They may add structure to an already existing neurotic framework or, in some instances, create a new pattern. Examples from daily ward rounds are made.

Glaucoma in General Practice

A. D. BEAM, M.D.

Early detection of glaucoma depends greatly upon the general practitioner, for often by the time the symptoms have become gross enough to lead the patient to an ophthalmologist, it is already "too late."

This presentation is offered to alert the general practitioner to the glaucoma menace and summarize specific information as to the diagnosis of glaucoma.

Congenital Urologic Lesions in Children

G. W. SEWELL, M.D.

The genito-urinary tract is the most common site for congenital anomalies. It is estimated that 35-40 per cent of all congenital abnormalities involve the G-U system.

The most commonly encountered lesions are dis-

cussed emphasizing those causing obstruction and associated pathology. The various signs and symptoms will also be brought out in the discussion. Illustrative cases will be presented showing x-ray findings.

The congenital abnormalities can be grouped into two clinical classifications. Those which are obvious at birth and are easily recognized. This group includes hypospadius, epispadius, patent urachus, and extrophy of the bladder. Some of the problems of management of this group are brought out.

The second group comprises those cases which are not readily obvious and usually involve urinary obstruction. These cases are discovered when the patients develop sepsis. The importance of hematuria and pyuria is emphasized in the discovery of this group. Included in this classification are congenital urethral valves, strictures, vesical neck obstruction, bladder diverticulae, ureterocele, ureteral stricture, ureteral valves and aberant vessels.

The early recognition and correction of these lesions thereby preventing many renal cripples is brought out in the conclusion.

Solitary Cyst of the Kidney

WATSON BEACH, M.D.

Solitary renal cyst is a comparatively rare disease. Such cysts are generally unilateral and are either serous or hemorrhagic. They arise from the renal cortex and usually project from the surface; they are found in connection with the lower pole, the upper pole and the mid-portion, in that order. The etiology is still theoretical. Very few are malignant. They are found most frequently in the adult, from ages thirty to sixty and very seldom in the young.

It is usually impossible to dissect out the cyst *in toto*. The projecting portion of the cyst is usually resected, the lining treated with cauterization of some type and the defect in the renal surface closed.

A recent case operated at this hospital is of interest for these reasons: A solitary cyst 3.5 cm. in diameter in the right kidney of a girl of seventeen years produced enough distress in the right loin to demand hospitalization and intravenous pyelogram; the cyst was found just above the middle of the kidney projecting from the lateral surface. It was removed *in toto* without rupturing. There were no urinary tract findings or symptoms other than the localized pain and the pyelograms.

One Thousand Appendectomies, a Clinicopathologic Correlation

J. A. KASPER, M.D.

One thousand appendices removed over a period of five years are classified as normal, atrophic, atrophic with fecal obstruction, chronic, chronic recurrent, chronic obliterative, lymphoid hyperplasia, acute catarrhal appendicitis, acute appendicitis, subacute, acute suppurative, acute suppurative with fecal impaction (fecalith), gangrenous with fecal impaction, gangrenous and miscellaneous types, including neoplasms, foreign body inclusion and worm inclusions. These will be correlated with clinical manifestations.

Esophageal Hiatus Hernia

J. B. HARTZELL, M.D.

Esophageal hiatus hernia occurs far more frequently than is generally realized. The vast majority are asymptomatic. A few do cause symptoms of sufficient severity to warrant repair. These symptoms may simulate gall-bladder disease or peptic ulcer.

The difficulties encountered in the diagnosis are enumerated, and a new simplified method of repair is described.

Osseous Defects—Lumbo-Sacral Joint

F. J. KELLEY, M.D.

The lumbo-sacral joint is designated as the particular site of a variety of osseous defects, which in themselves may not be of great importance but which, when complicated by even slight trauma, can cause severe and possibly incapacitating low back pain. This is due to the fact that in these architectural abnormalities, the articular processes often leave the supportive function of the spine to the ligaments as a substitute, and these latter soon lose their supportive qualities.

Six common abnormalities are illustrated by lantern slides and reviewed as to the mechanical causes for the symptoms produced.

The conclusion has to do with the disposition of those cases which have passed to an unfavorable stage of chronicity rendering conservative treatment futile. It must be realized that these cases comprise a definite pathological entity which, in the patient's best interests, demand consideration of more radical therapy.

Plastic Surgery in Carcinoma of Head and Neck

E. J. HILL, M.D.

No abstract.

Gangrene of the Testicle

I. G. DOWNER, M.D.

Torsion of the spermatic cord, while not of great frequency, is an important pathological entity demanding early recognition and surgical intervention. It is of interest to note that in one large series of cases reviewed that almost 75 per cent resulted in loss of the testicle. This is seemingly a high toll to be paid for a condition in which rather typical signs and symptoms are present from the onset. The most constant symptoms are sudden onset for severe, unrelenting testicular

pain, frequently accompanied by nausea and vomiting and marked prostration. A history of previous attacks is not infrequently obtained. The exact cause of torsion remains obscure. When torsion is suspected, scrotal exploration should be done immediately. Treatment consists of reduction of the torsion and orchiopexy; if gangrene, orchidectomy. A case report with lantern slides is presented.

Irradiation and Sugical Treatment of Deafness

J. E. Coyle, M.D.

While the majority of cases of deafness are due to cochlear deterioration and thus refractory to treatment, a great number of handicapped patients can be aided by either surgical intervention or irradiation or a combination of the two. The present status of radium therapy is reviewed in the light of recent controversy. The importance of an adequate adenoidectomy is particularly stressed. The fenestration operation is also discussed.

The Newer Concepts of Atherosclerosis

Hugh Stalker, M.D.

Atherosclerosis is the most important among the several disease entities which together comprise the generic grouping arteriosclerosis. At least 90 per cent of all myocardial infarctions are atherosclerotic in origin. Today the long prevalent attitude that atherosclerosis is a physiologic process of aging has been irrevocably rejected.

There are no known substances which have been proven to be causually related to human atherosclerosis although there are many factors which are associated with the development of atherosclerosis in humans. These entities which are found in the serum include cholesterol (free, esterified, and total) lipid phosphorous, total lipids and neutral fats, Sf 10-20 molecules and alpha and beta lipoproteins. One or more of the substances, while not by themselves causally related to atherosclerosis, may actually be a gross reflection of the metabolic error.

It has been well documented that one or more of these chemical entities occur in excessive amounts in the sera of humans who overtly manifest atherosclerosis.

Abnormalities of the Placenta

R. G. Swanson, M.D.

A review of the more common types of placenta and umbilical cord abnormalities including a short discussion of clinical importance and management.

The Surgical Management of Lesions of the Liver and Bile Ducts in Infants and Children

C. D. Benson, M.D.

Lesions of the liver and bile ducts are not of common occurrence in infants and children but their true significance must be realized so that definitive surgery can be performed. A review of lesions of congenital, traumatic and infectious origin will be described and the important diagnostic points will be discussed. The various surgical procedures used will be illustrated by lantern slides.

Roentgen Study of the Acute Abdomen

E. F. Lang, M.D.

Roentgen study by scout films of the patient with an abdominal catastrophe can be done rapidly, simply, and with a minimum of disturbance to the patient. The examination may be of great value in any one of several ways. It may confirm a clinical suspicion, as by disclosing free intraperitoneal air in suspected perforation of a hollow viscus. It may aid in establishing one of two possibilities by exclusion of the other, as when the choice is between ureteral calculus and appendicitis. The examination may present pathognomonic signs of some underlying condition which was not suspected on the basis of clinical evidence, as in a ruptured aortic aneurysm presenting with urinary tract symptoms. The course of a disease as shown by two films made a few hours apart may be decisive in determining the proper therapeutic approach.

The aid which may be anticipated from roentgen study in specific types of acute gastrointestinal, vascular, peritoneal, urological, gynecological, traumatic, and other lesions will be described.

Diagnostic Cerebral Arteriography

G. R. Granger

No abstract.

Some Psychosomatic Aspects of Convulsive Disorders

H. W. Bird, M.D.

The convulsive patient is a total personality in whom psychologic and physiologic functions are intimately inter-related. Not only do the manifestations of the physical disorder produce emotional disturbances, but psychologic factors may also be important in the genesis of the seizures. Recent studies, for example, have shown that the convulsive episode in the "essential" epileptic represents a sudden discharge of dammed-back affect in a predisposed individual. This discharge often "clears the air" psychologically for varying periods of time in the previously disturbed epileptic. The converse is also true. Patients are known to have had their first grand mal convulsion following denial of all natural forms of expression of aggressive feelings. It is necessary to study the personality structure and the specific life experiences of the epileptic to understand the role of emotional forces in seizure formation.

The Big and Little AMA

I have just returned from attending the 102nd Annual Session of the American Medical Association in New York City, the largest medical meeting ever held in what is now the largest city in the world. The registration was approximately 40,000, including 18,000 doctors of medicine, so one can easily sense the immensity of the program.

Attending the meetings of the House of Delegates was one of my privileges. I was impressed with the democratic manner in which the proceedings are conducted, albeit our Michigan delegates offered resolutions, which were favorably acted upon, that will even improve the democratic procedures of the organization. One could also sense that the AMA is assuming its important position as the voice of the profession at large and the private practice of medicine.

Among the notables speaking to the delegates was Oveta Culp Hobby, Director of the Federal Department of Health, Education and Welfare, who reassured us on much of our philosophy of the practice of medicine but also cautioned that there are gaps to be filled and urged expansion of the voluntary health plans that have already assumed such importance in our own state. She assured us that the special assistant in the Department for Health and Medical affairs would be a doctor of medicine.

Despite the greatness of the AMA, I nevertheless am proud to be a member of the Michigan State Medical Society and to be a part of our Annual Session that will be held in Grand Rapids September 23-24-25. You should know that our executive force aids in planning and supervising a state meeting that is second to none—that is frequently called "The Little AMA"—so we shall be looking forward to seeing all of you in Grand Rapids in September.

President's Message

R. J. Hubbell

President, Michigan
State Medical Society

Editorial

A BUSY ANNUAL SESSION

THE ONE hundred second Annual Session of the American Medical Association was held in New York City, June 1 to 5, 1953. The scientific part of the convention was marked by the largest number of papers ever offered; the finest advanced thought and experience of the profession's leaders in science, research and the art of medicine. The meetings of the sections were crowded. Mostly there was standing room only. The scientific and technical exhibits occupied four floors of the Grand Central Palace.

The most vital part of the convention was the business and official proceedings of the House of Delegates. The American Medical Association is a vast democracy. Delegates are elected from the various states, from the sections and from the Federal services to the number of 185. These men meet formally to transact the business and set the policies of the medical profession. Their devotion to duty and responsibility are testified to by the fact that only four vacancies were recorded. From the states there are also Alternates who serve if Delegates are not present, and most of the states sent their Alternates as well as the Delegates.

In organizing the House fourteen reference committees are appointed to which are referred all resolutions introduced. There are stated times for the sessions of the House of Delegates, after which the reference committees go to work in separate assigned rooms. Any member of the House or of the AMA may appear before these committees and discuss any pending resolutions. The sessions are long, frequently last almost throughout the night, and this continues for four days, until the business of the House is completed.

We may have no fear for the welfare of the profession when all these brilliant, learned and experienced men give of their time and strength to arrive at proper solutions to important questions and policies. To illustrate the procedure let us consider the Michigan Delegation—a typical one. They had numerous caucauses at which all questions which had developed in the House of Delegates were discussed and each man was given full knowledge of the implications. Each morning the Michigan delegation had breakfast at eight to review the past actions and assay the future. With such concentration and devotion the very best interests of the individual practitioner of medicine will prevail.

CALM JUDGMENT

THE FIRST forenoon session of the House of Delegates, June 1, saw over seventy resolutions introduced. These covered many questions and included a few very touchy and controversial topics. The handling of one in particular (Dr. Hawley) impressed us with the ultimate just and proper management of the affairs of the Society. All is well.

Eleven resolutions were presented dealing with publicity regarding unethical conduct of physicians as a result of recent newspaper and magazine articles reporting statements attributed to an official spokesman of an allied medical organization. Hours of hearings, and much newspaper comment resulted in action by the House on a committee recommendation not to adopt any of the resolutions but to reaffirm the American Medical Association Principles of Ethics. The House adopted this statement of principle:

"The Principles of Medical Ethics as formulated, interpreted and applied by the American Medical Association must be considered the only fundamental and controlling application of ethics for the entire profession. . . . Any statement relating to ethical matters by other organizations within the general profession of medicine advances views of only a particular group and is without official sanction of the entire profession as represented by the American Medical Association. . . . The harm done to the public and the profession by the current articles which lower the confidence patients have in their doctors cannot be objectively evalu-

ated. . . . When individuals or groups without official status in the American Medical Association utter or publish ill-considered statements, the result too often is that the confidence of the public in the medical profession is placed in jeopardy. . . . Broad generalizations, ill-advised and poorly prepared statements that often fail to convey the intended meaning are most unfortunate and are to be deplored. Destructive critical comments serve no useful purpose."

We submit this as a masterpiece of statesmanship. Where such a result may follow, we may have no fears. The American Medical profession is in good hands.

RELATIONS BETWEEN OSTEOPATHY AND MEDICINE

THE most controversial subject before the House of Delegates at this session was that presented by the Committee appointed by the Board of Trustees two years ago, to Study the Relations between Osteopathy and Medicine. The report is long and was read in full to the House before going to the Reference Committee. After two hours of spirited debate the House adopted a committee report postponing action until June, 1954, and allowing further study by the delegates and by state associations.

The recommendations of the committee were for further study at the state level, and we believe they should be passed on to the profession for its consideration. They follow:

"1. That the House of Delegates declare that so little of the original concept of osteopathy remains that it does not classify medicine as currently taught in schools of osteopathy as the teaching of 'Cultist' healing.

"2. That the House of Delegates state that pursuant to the objectives and responsibilities of the American Medical Association which are to improve the health and medical care of the American people, it is the policy of the Association to encourage improvement in the undergraduate and postgraduate education of doctors of osteopathy.

"3. That the House of Delegates declare that the relationship of doctors of medicine to doctors of osteopathy is a matter for determination by the state medical associations of the several states and that the state associations be requested to accept this responsibility.

"4. That the Committee for the Study of Relations between Osteopathy and Medicine or a similar committee be established as a continuing body."

The committee report accepted included the following recommendation of the Board of Trustees:

"Because of the length of this report and the controversial nature of the subject, the Board feels that the House should have adequate time for study, and that the state associations should have opportunity to express their opinions. Therefore it is recommended that the Committee be continued, but that action on the report be deferred until the June, 1954, session. It is suggested that at that time the House be prepared to answer the following questions:

"1. Should modern osteopathy be classified as 'cultist' healing?

"2. Since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education should doctors of medicine teach in osteopathic schools?

"3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter of determination by the several state associations?"

June, 1954, is assigned for the official action on this question. For that reason we have felt this statement should be available to our members before the annual session of the Michigan State Medical Society in September.

THE SCOPE OF PUBLIC HEALTH

(Continued from Page 733)

with a program for expansion of the scope of a public health program, as serving in the role of loyal opposition. I am confident that organized medicine and public health are equally loyal to the same high ideals—the promotion of the health and well-being of mankind. I trust that as public health broadens in scope as it is broadening in response to the mandate of the people, we may work out our differences of opinion with full trust and mutual respect for each other.

The Tornado That Tore Flint

Courtesy of *The Flint Journal*

Howling out of the sky, the tornado which struck Flint, Michigan, left a scene of complete devastation. In two minutes Nature on the rampage brought destruction, suffering and death.

(An on-the-spot report made for JMSMS by officers of the Genesee County Medical Society)

On June 8, at 8:34 P.M. a tornado ripped through the north end of Flint cutting a wide swath from west to east through a densely populated area. In its wake were 132 now known dead and hundreds injured.

By 9 p.m. news of the devastation had spread by radio and word of mouth and by 9:15 p.m. doctors were in our hospitals caring for the injured.

A catastrophy of this magnitude produces many heroes; hundreds of everyday people demonstrate the innate goodness of humanity in thousands of little jobs they do. For this reason, it is unfair to single out any one group for meritorious service. But for purposes of this publication the doings of the medical group is recounted for the interest of its readers.

Three Hospitals Became Centers of Mercy

Flint has three general hospitals, and all have open staffs. Department heads serve on a voluntary basis and staff organization exists more on paper than in reality except for resident training. For this reason, doctors were free to go to any one of the hospitals. It was simply amazing how they began to show up without being called and the distribution of personnel was about right considering the voluntary setup.

At this early date (June 9) accurate statistics are not available but it is estimated that at least 500 persons were seen in the three hospitals before daylight. The emergency room became the nerve center of the group. From there patients were sent to x-ray, to an improvised ward for instant

treatment, or immediately to surgery for such things as depressed skull fractures, severe lacerations, crushed chests, et cetera. Many were examined, given minor treatment and sent to an emergency rest ward on cots to await definitive treatment the next day.

One essential policy stands out for all such catastrophes: What can wait until later must wait; the serious case comes first and time must not be devoted to treatment unless it is a life-saving measure at that moment.

Volunteer M.D.'s Organized Swiftly

The following morning found the volunteer staff members in each hospital busy with more definitive care of the hospitalized. Fracture teams began the day-long process of setting, casting, and open reductions. Eye men set about looking closer at eyes, chest surgeons inspected a little closer and found a few more collapsed lungs to re-expand. Urologists looked at bladders and kidneys where injury had been doubtful.

Doctors did not bother with names and addresses and obviously didn't think once of fees. All services were truly volunteered. Many practically worked the clock around.

Flint is grateful for the kind offers of assistance from Doctors in Detroit, Ann Arbor, Jackson, et cetera. There were more than this writer knows about.

Especially wonderful was the way all the other medical personnel worked. Nurses just materialized out of nowhere and went to work. Lab technicians and x-ray technicians from all over the city arrived at the hospitals and just went to work. There was no confusion or fuss—just an efficient crew doing a job that had to be done.

Fractures — Burns — Dirt!

Certainly fractures led in numbers of significant injuries, but one was amazed that nearly every victim was covered with brush burns, and the awful dirt! It was literally blown and ground into the skin as if by a pressure gun.

If you would ask for the "system" used in Flint, it could not be defined. As far as we know, there was no official, pre-assigned post for each doctor, nor for other medical personnel. Yet, somehow each one knew where he could do the most good and went there. After that, it was just the sincere desire to help that made it work. In less than twenty-four hours after disaster struck, doctors were back in their offices practicing medicine and most of the victims were patched up and on the mend.

All Helped

A radio appeal brought blood donors to the hospital in such droves that they clogged halls. Blood letting was continued all night long with a pathologist in charge at each hospital. Over 400 pints were drawn.

High tribute is due the organized first aid groups that actually worked in the disaster area, and the many volunteers who used panel trucks and cars to bring in the injured. These lay people completed the team that cared for the injured.

PSYCHOSOMATIC APPROACH TO CONVULSIVE DISORDERS

(Continued from Page 743)

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Welcome to Grand Rapids

Valuable scientific information with practical and clinical application is a stellar attraction to the hundreds of Michigan and midwestern doctors of medicine who will attend the Michigan State Medical Society Annual Session in Grand Rapids this September.

lind Hotel and the Civic Auditorium in Grand Rapids.

No doctor of medicine wants to miss out on the valuable information available to him in the lecture halls and in the scientific and technical exhibits. There will be 143 technical and scientific

The 88th Annual Session is tailor-made to M.D. specifications. It's Michigan's greatest scientific event.

For three informative and stimulating days—September 23-24-25—a total of twenty-seven scientific medical teachers from every important medical center of the United States will report on the latest in scientific and medical information. The 88th Annual Session will be held at the Pant-

exhibits in the vast Civic Auditorium exhibition hall all displaying the most recent of medical supplies and equipment available to the medical profession.

Amid the scientific events of the three-day meeting a dash of fun is thrown in for good seasoning. The social programs will be of great interest to the doctors and their wives. Officers' Night on Wednesday, September 23, features United States

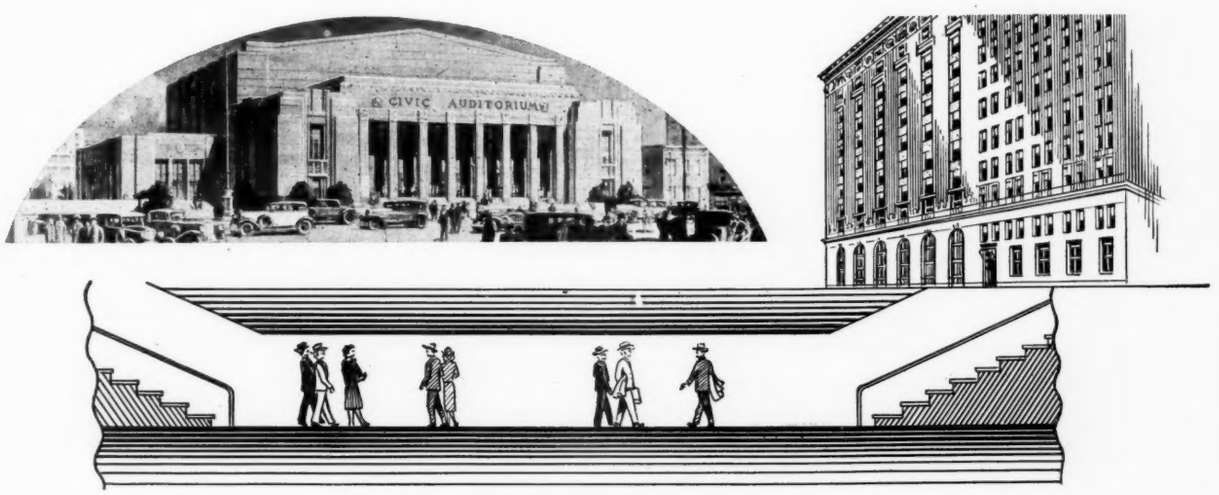
Senator Homer P. Ferguson as the Biddle Lecturer. The following night, Thursday, September 24, the Michigan State Medical Society will be hosts to all registrants and their guests at the State Society Night.

This year the daily Discussion Conferences will be conducted again during the noon period from 12:00 until 1:00 P.M. During this time all of the day's scientific speakers offer the registrants an excellent opportunity to review and discuss the day's scientific events. Thus, these informal events give the visiting M.D.s a chance to pursue further questions for amplification on the topics of the day with the answers coming directly from the outstanding specialists appearing on the day's program.

In addition to the meeting of M.D.s, their wives and medical assistants will hold concurrent meetings in other parts of the Pantlind Hotel. The Woman's Auxiliary to the Michigan State Medical Society has scheduled a three-day meeting—September 23-24-25—to consider the affairs of the Auxiliary. The Michigan State Medical Assistants Society will conduct its Fourth Annual Convention on Wednesday and Thursday, September 23 and 24.

A cordial invitation is extended to all M.D.s in Michigan and the surrounding states to attend and take part in this outstanding medical event of the year. Besides providing a beneficial experience for every medical practitioner, the 88th Annual Session also offers a time of fellowship and a chance to renew old acquaintances.

The valuable information available will benefit you, as a practicing doctor of medicine—and it will benefit your patients. You won't want to miss this



Civic Auditorium Concourse Pantlind Hotel

HOTEL AND MEETING ROOMS ALL UNDER ONE ROOF

Michigan State Medical Society

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1869—*Richard Inglis, Detroit
1870—*I. H. Bartholomew, Lansing
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1917—*Andrew P. Biddle, Detroit
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1934—*R. R. Smith, Grand Rapids
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1936—*Henry E. Perry, Newberry
1937— Henry Cook, Flint
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1941— Henry R. Carstens, Detroit
1942— H. H. Cummings, Ann Arbor
1943— C. R. Keyport, Grayling
1944—*A. S. Brunk, Detroit
1945—*V. M. Moore, Grand Rapids
(Died before taking office)
1945— R. S. Morrish, Flint
1946— Wm. A. Hyland, Grand Rapids
1947—*P. L. Ledwidge, Detroit
1948— E. F. Sladek, Traverse City
1949—Wilfrid Haughey, Battle Creek
(President-for-a-Day, Sept. 21, 1949)
1949—W. E. Barstow, St. Louis
1950—C. E. Umphrey, Detroit
1951—Otto O. Beck, Birmingham
1952—R. L. Novy, Detroit
(President-for-a-Day, Sept. 22, 1952)

*Deceased.

Floor Show—State Society Night

September 24, 1953

NIP NELSON

GEORGE WEST AND MAZA

TANYA AND BIAGI

Nip Nelson, the Chicago wit of television, radio and night club, will headline the all-star floor show presented to MSMS Annual Session registrants and their guests in the Ballroom of the Pantlind Hotel, Grand Rapids, Thursday evening, September 24.

Nip Nelson jam-packs several hundred belly-laughs into his forty-minute sketch of impersonations and subtle humor. His act defies adequate description. One must be present to "get" the fast act of Nip Nelson. You'll roar!

Tanya and Biagi, a comedy dance team, experience an alarming series of mishaps, progressing with Biagi's coat ripping apart and beautiful Tanya losing important parts of her stunning wardrobe. Through all this laugh-provoking act, the audience is fully aware of the fine acrobatic and dance style of these two clever and amusing artists.

George West and Maza head a most unique musical comedy, audience participation act. This riotous performance with the aid of a prop piano, musical instruments, and a couple of members of the audience, is sure fire comedy.

Your host will be the Michigan State Medical Society.

Michigan State Medical Society

The 88th Annual Session

CIVIC AUDITORIUM—PANTLIND HOTEL, GRAND RAPIDS, MICHIGAN

September 21, 22, 23, 24, 25, 1953

ANNUAL SESSION INFORMATION

DIRECTORY

Headquarters—Civic Auditorium—Pantlind Hotel, Grand Rapids

Registration—Civic Auditorium Exhibition Hall (see hours below)

Assemblies—Black and Silver Ballroom, Civic Auditorium

House of Delegates—Monday, Tuesday, September 21-22, Pantlind Hotel

Exhibits—Civic Auditorium

Press Room—Room F, Civic Auditorium

Woman's Auxiliary Headquarters—Pantlind Hotel

Michigan State Medical Assistants Society Headquarters —Pantlind Hotel

- **REGISTER**—Civic Auditorium—as soon as you arrive.

  Hours:

  Tuesday, September 22, 1:00 p.m. to 5:00 p.m.
  Wednesday, September 23—7:30 a.m. to 5:00 p.m.
  Thursday, September 24—8:30 a.m. to 5:00 p.m.
  Friday, September 25—8:30 a.m. to 3:30 p.m.

- **NO REGISTRATION FEE FOR MEMBERS OF MSMS AND OTHER STATE MEDICAL ASSOCIATIONS, AMA, AND CANADIAN MEDICAL ASSOCIATION.**

  Admission will be by badge only to all Scientific Assemblies, Section Meetings, Discussion Conferences and the Exhibition. Please present your MSMS or other State Medical Association, AMA, or CMA Membership card to expedite your registration. We wish to save your time.

MSMS Secretary L. Fernald Foster, M.D., Bay City, as "fun-processed" by his friend, C. L. A. Oden, M.D., Muskegon.

* * *

- **GUESTS**—Members of any state medical association, AMA, or CMA members from any province of Canada, and physicians of the Army, Navy and U. S. Public Health Service are invited to attend, as guests. No registration fee. Present credentials at the Registration Desk.

  Bona fide doctors of medicine serving as residents, interns, or who are associate or probationary members of Michigan county medical societies, if vouched for by an MSMS Councilor or the president or secretary of the county medical society in whose jurisdiction they practice, will be registered as guests. Present credentials at the Registration Desk.

* * *

- **MICHIGAN DOCTORS OF MEDICINE,** in practice but who are not members of MSMS, if listed in the American Medical Directory, may register as guests upon payment of $25.00. This amount will be credited to them as dues in the Michigan State Medical Society FOR THE BALANCE OF 1953 ONLY, provided they subsequently are accepted as members by the County Medical Society in whose jurisdiction they practice.

* * *

- **DOCTOR,** register Tuesday! Registration of physicians will be held Tuesday afternoon from 1:00 to 5:00 p.m.—as well as on Wednesday, Thursday, Friday, during the 1953 MSMS Annual Session. The Tuesday afternoon registration hours are arranged so that physicians may avoid waiting in line Wednesday morning before the opening Assembly.

  We recommend to Grand Rapids physicians—and those who arrive in Grand Rapids on Tuesday—that they register Tuesday, September 22, from 1:00 to 5:00 p.m., Civic Auditorium.

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- **TELEPHONE SERVICE**—Special lines to handle local and long distance telephone service for registrants at the MSMS meeting are available in the Civic Auditorium just outside the Black and Silver Ballroom Glendale 1-9213, Glendale 1-9751, Glendale 1-9156. To contact the Exhibit Hall, call: Glendale 1-9145, Glendale 1-9403, Glendale 1-9738. The telephone number at the Pantlind Hotel is 9-7201.

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- **GUEST ESSAYISTS** are very respectfully requested not to change time of their lecture with another speaker without the approval of the Assembly. This request is made in order to avoid confusion and disappointment on the part of some members of the audience.

NEW INFORMATION IN THE HUGE EXHIBIT—Many items of interest or education will be found in the large exhibit of 143 scientific and technical displays. The Exhibit Section at MSMS Annual Sessions is as important, informative and desirable to most doctors of medicine as the scientific papers presented in the Assembly room. Doctor, stop at every booth—you'll be surprised how much you'll learn! No high-pressure salesman but a courteous well-informed exhibitor will greet you and supply you with some valuable information helpful to your patients.

- **CHECK ROOM**—Both in Civic Auditorium and Pantlind Hotel.

* * *

- **PUBLIC MEETING** — The evening Assembly of Wednesday, September 23—Officers Night—will be open to the public. Invite your patients and other lay friends to this entertaining meeting, to be held in the Black and Silver Ballroom of the Civic Auditorium at 8:30 p.m. Program on page 764.

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- **CABARET-STYLE DANCE AND FLOOR SHOW,** with the compliments of the Michigan State Medical Society, will be held in the Ballroom of the Pantlind Hotel at 10:30 p.m. All who register, and their ladies, will receive a card of admission and are cordially invited to attend.

* * *

- **TRANSPORTATION**—The C & O Streamliners afford a convenient means of transportation to the MSMS Annual Session in Grand Rapids for hundreds of physicians located in the southeastern and Central parts of the State.

* * *

- **PARKING**—Metered parking on the streets surrounding the Pantlind Hotel and Civic Auditorium. Outside lots are available as follows:
  1. Rear of Rowe Hotel (two blocks from Pantlind Hotel).
  2. Campau Avenue parking lot (one and one-half blocks from Civic Auditorium).

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- **THE ANNUAL COMMITTEE ORGANIZATION** luncheon, a meeting of MSMS committee chairmen appointed by President-Elect L. W. Hull, M.D., Detroit, to serve during the year 1953-54, will be held on Thursday, September 24, in the Sadler Lounge, Pantlind Hotel, at 12:30 p.m.

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- **POSTGRADUATE CREDITS** are given to every MSMS member who attends the Annual Session.

SECTION MEETINGS—on Wednesday-Thursday-Friday, September 23-24-25, immediately following adjournment of the daily Assembly.

WEDNESDAY, SEPTEMBER 23, 5:00 to 6:00 p.m. The following Sections will meet: Nervous and Mental Diseases; Ophthalmology; Pediatrics; Surgery; and Urology.

THURSDAY, SEPTEMBER 24, 5:00 to 6:00 p.m. The following Sections will meet: Gastroenterology and Proctology; General Practice; Obstetrics-Gynecology; and Otolaryngology.

FRIDAY, SEPTEMBER 25, 5:00 to 6:00 p.m. The following Sections will meet: Dermatology and Syphilology; Medicine; Pathology; Public Health and Preventive Medicine, and Radiology.

- **THE 143 TECHNICAL AND SCIENTIFIC EXHIBITS**—The Scientific and Technical displays will open daily at 8:30 a.m. and close at 5:15 p.m., except on Friday when the break-up is at 3:30 p.m. Frequent intermissions to view the educational exhibits have been arranged before, during, and after the Assemblies.

* * *

- **THE MSMS HOUSE OF DELEGATES** convenes Monday, September 21, at 10:00 a.m., Ballroom, Pantlind Hotel; it will hold three meetings on Monday, September 21, at 10:00 a.m., 2:00 p.m. and at 8:00 p.m.; also two meetings on Tuesday, September 22, at 9:30 a.m. and at 8:00 p.m.

PRE-REGISTRATION OF DELEGATES WILL BE HELD SUNDAY, SEPTEMBER 20, FROM 8:00 TO 10:00 P.M. PLEASE REGISTER IN ADVANCE AND SPARE YOURSELF STANDING IN LINE MONDAY MORNING.

* * *

- **W. C. BEETS, M.D.,** Grand Rapids, is General Chairman of Arrangements for the 1953 MSMS Annual Session in Grand Rapids.

The Scientific Press Relations Committee is composed of: C. A. Payne, M.D., Chairman, F. C. Brace, M.D., H. G. Benjamin, M.D., and P. W. Kniskern, M.D., all of Grand Rapids.

INFORMATION OF PRACTICAL VALUE IN DAILY PRACTICE will be found at the Michigan State Medical Society Annual Session. All subjects on the MSMS Annual Session Program are applicable to clinical medicine. They stress diagnosis and treatment, usable in everyday practice.

- **PAPERS WILL BEGIN AND END ON TIME**—Believing there is nothing which makes a scientific meeting more attractive than by-the-clock promptness and regularity, all meetings will open exactly on time, all speakers will be required to begin their papers exactly on time and to close exactly on time in accordance with the schedule in the program. All who attend the meeting, therefore, are requested to assist in attaining this end by noting the schedule carefully and being in attendance accordingly. Any member who arrives five minutes late to hear any particular paper will miss exactly five minutes of that paper!

* * *

"Surgical Block" Wednesday morning—the four Assembly periods of Wednesday morning, September 23, will be devoted to surgical subjects. This "Surgical Block" will complement the program arranged by the newly formed Michigan Chapter, American College of Surgeons which will hold its initial meeting on Tuesday afternoon, September 22, to coincide with the MSMS Annual Session.

The Surgical Section will meet Wednesday at 5:00 p.m. in the Black and Silver Ballroom, Civic Auditorium.

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"General Practice Day"—Thursday, September 24, 1953. The Assembly subjects on the second day of the MSMS Annual Session are beamed to general practitioners. The General Practice Section meets Thursday at 5:00 p.m. in the Black and Silver Ballroom, Civic Auditorium.

The Day will be further featured by the presence in Grand Rapids of U. R. Bryner, M.D., Salt Lake City, President of the American Academy of General Practice—who will address the Michigan Academy of General Practice at its dinner meeting Thursday evening.

THREE DISCUSSION CONFERENCES

Three quiz periods will be held Wednesday-Thursday-Friday, September 23-24-25, Black and Silver Ballroom, Civic Auditorium, 12:00 noon to 1:00 p.m. with all the guest speakers of the day on the platform.

An opportunity to ask questions concerning the presentations of the guest essayists, or to discuss an interesting case with them, is provided at these Discussion Conferences.

A CONCENTRATED THREE-DAY POSTGRADUATE COURSE—A CAPSULE OF GREAT VALUE TO THE MICHIGAN PRACTITIONER OF MEDICINE—THAT'S THE MSMS ANNUAL SESSION OF 1953.

* * *

The First Beaumont Lecture of the Michigan State Medical Society, Friday, September 25: recently created by The Council of the Michigan State Medical Society, the premiere MSMS Beaumont Lecture will be presented by J. A. Bargen, M.D., Rochester, Minnesota, on Friday, September 25 at 9:00 a.m. Dr. Bargen's subject will be: "Problems of Nutrition in Ulcerative Conditions of the Digestive Tract."

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• MEETINGS OF SPECIAL SOCIETIES, ALUMNI AND AUXILIARY GROUPS

Tuesday, September 22, 1953

1. **Michigan Chapter American College of Surgeons,** 2:00 p.m., Scientific program, Kent State Room; 5:00 p.m. cocktails, Continental Room; 7:00 p.m. dinner, Kent State Room.

2. **The Michigan Branch of the American Academy of Pediatrics** will hold a meeting Tuesday, September 22, beginning at 9:00 a.m. The morning scientific meeting will be a clinical conference at Blodgett Hospital, Grand Rapids. Dietetic lectures will be presented in the afternoon in the Schubert Room, Pantlind Hotel, 2:00 p.m.

   Sidney Farber, M.D., Boston, will present a talk entitled "The Management of Malignancies in Childhood."

   There will be reception at 5:30 p.m. in the Sadler Lounge honoring Doctor Farber. Dinner at 6:30 p.m. in the Schubert Room of the Pantlind Hotel.

   Sponsors of the afternoon program and of the cocktail party and dinner are the Baker's Laboratories of Cleveland and Gerber Products Company of Fremont, Michigan.

Wednesday, September 23, 1953

3. **The Michigan Chapter, American College of Chest Physicians** will hold a dinner-meeting in Room 328 of the Pantlind Hotel beginning at 6:30 p.m.

4. **The Detroit Branch of the American Urological Society** will meet jointly with the MSMS Section on Urology beginning at 5:00 p.m. in Rooms D and E in the Civic Auditorium followed by a social hour and dinner at 6:00 p.m. in the Schubert Room, Pantlind Hotel.

5. **The Michigan Association of Alpha Kappa Kappa** will hold its annual meeting in Rooms 323-325, Pantlind Hotel, starting with cocktails at 5:30 p.m. and dinner at 6:30 p.m.

6. **The Michigan Society of Neurology and Psychiatry** will meet for cocktails at 6:00 p.m. in Room 327, followed by dinner at 6:30 p.m. in Room 222, Pantlind Hotel. O. Spurgeon English, M.D., of Philadelphia will be guest speaker.

7. **The MSMS Section on Ophthalmology** will hold a dinner-meeting beginning at 6:30 p.m. in Rooms 322-324, Pantlind Hotel.

Thursday, September 24, 1953

8. **The Michigan Academy of General Practice** will meet at 6:00 p.m. for cocktails with dinner at 7:00 p.m in the Continental Room, Pantlind Hotel. U. R. Bryner, M.D., of Salt Lake City, Utah, President of the American Academy of General Practice, will be guest speaker at this dinner-meeting.

9. **The Michigan Chapter of the Arthritis and Rheumatism Foundation** will meet for cocktails at 6:30 p.m. in Room 328 followed by a dinner meeting at 7:30 p.m. in Room 327, Pantlind Hotel. All members of the Chapter's Medical Advisory Committee are cordially invited to attend.

10. **The Wayne University College of Medicine Alumni Association** will hold an alumni banquet in the Schubert Room of the Pantlind Hotel at 6:00 p.m. Alumni, their wives and guests are cordially invited to attend. Tickets will be available at the Wayne University scientific exhibit booth. Dean Gordon H. Scott, Ph.D., Detroit, will give a report for the Medical School to the alumni. Don F. Strohschein, M.D., Detroit, will be chairman of the banquet program which will be dismissed in time for the alumni to attend the State Society Night entertainment. A Wayne University Alumni headquarters suite will be maintained in the Pantlind Hotel during the Annual Session.

11. **Upper Peninsula Day** is scheduled for 6:30 p.m. (cocktails) followed by dinner at 7:30 p.m. in The Sadler Lounge of the Pantlind Hotel.

12. **The Michigan and Detroit Proctologic Society** will hold a dinner-meeting at 6:00 p.m. in Rooms 322-324, Pantlind Hotel.

13. **The Michigan Diabetes Association** will meet for cocktails at 6:30 p.m. in Room 323 followed by dinner at 7:30 p.m. in Room 325.

Friday, September 25, 1953

14. **The Michigan Pathological Society** will meet at 3:00 p.m. in the Continental Room, Pantlind Hotel, and for dinner at 6:00 p.m. in the Sadler Lounge, Pantlind Hotel.

Women's Organizations

15. **The Woman's Auxiliary to the Michigan State Medical Society** will meet as follows:

September 21, 22, 23, 1953

Headquarters, Hotel Pantlind, Grand Rapids, Michigan

(Registration from 10:00 A.M. Tuesday through Thursday noon on Mezzanine)

MONDAY—September 21

P.M.
6:30 Finance Committee Dinner meeting—President's suite

TUESDAY—September 22

P.M.
6:30 Organization Dinner for Retiring and Incoming Directors and President Elect, Schubert Room, Pantlind Hotel
6:30 Past Presidents' and Secretaries' Dinner, Peninsular Club

WEDNESDAY—September 23

A.M.
9:30 Pre-Convention Board Meeting—Red Room, Civic Auditorium (for 1952-53 State Officers, Directors, State Chairmen and County Presidents)
10:30 Annual Two-day Session opens, Red Room, Civic Auditorium, Mrs. William Mackersie, President, presiding

P.M.
12:30 Luncheon, honoring Past State Presidents, Kent State Room, Pantlind Hotel
2:30 Resume General Session
4:00 Business adjourned until 9:00 Thursday
6:00 Annual Banquet, Kent State Room, Hotel Pantlind. (Dress Informal) Husbands cordially invited. Official representatives of MSMS will be our guests
8:30 MSMS Officers' Night. Biddle Lecture

THURSDAY—September 24

A.M.
9:00 Resume General Session of Annual Convention, including Election of Officers
12:00 M Annual Luncheon, Kent State Room, Hotel Pantlind. Speaker—Mrs. Leo J. Schaefer, President, Woman's Auxiliary to the AMA
Installation of Officers

P.M.
2:30 Adjournment
3:00-4:00 Post-Convention Board Meeting, Mrs. Walter S. Stinson presiding.
(For 1953-54 Officers, Directors, State Chairmen and County Presidents)
10:30 MSMS State Society Night—Floor show and dancing

16. **The Michigan State Medical Assistants Society Convention** will meet in the Pantlind Hotel, Grand Rapids, September 23 and 24, 1953.

WEDNESDAY—September 23

A.M.
9:00 Registration at Pantlind Hotel
9:30 MSMAS Executive Committee Board Meeting
10:00 "Cancer"
LUTHER C. CARPENTER, M.D., F.A.C.S., Grand Rapids
10:45 "Poliomyelitis"
DAVID G. DICKINSON, M.D., Director, National Foundation for Poliomyelitis, Washington, D. C.
11:30 "Legal Aspects in Medicine"
WILLIAM A. PERKINS, LL.B., Grand Rapids

P.M.
12:30 Luncheon, Ball Room, Hostess, MISS ANN DROLEN, Kalamazoo, sponsored by Michigan Medical Service
2:00 Annual Business Meeting and Election of Officers
4:30 View Exhibits
6:00-7:00 Cocktail Hour—Mezzanine
Sponsored by Professional Management of Battle Creek
7:30 Banquet, Ball Room, Hostess: MRS. CHARLOTTE ASH, Kalamazoo; "Your Attitude and You," A. E. SCHNEIDER, Ph.D., Professor of Education, Head of Business Department, Western Michigan College

THURSDAY—September 24

A.M.
9:00 Registration at Pantlind Hotel
10:00 "X-ray and X-ray Therapy"
EDWIN O. PEARSON, M.D., Kalamazoo
11:00 "Tuberculosis"
ANTHONY F. STILLER, M.D., Pine Crest Sanatorium, Oshtemo

P.M.
12:30 President's Luncheon—Schubert Room
Hostess: MRS. LORRAINE BURGESS, Grand Rapids
Style Show
2:00 "History of Medicine"
DR. HARVEY M. MERKER, Consultant in Pharmaceutical and Chemical Manufacturing, Parke, Davis & Company
4:30 View Exhibits
10:30 MSMS State Society Night—Floor Show

DATES TO REMEMBER

March 9, 1954—SECOND ANNUAL MEETING, MICHIGAN CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS

March 10-12, 1954—EIGHTH MICHIGAN CLINICAL INSTITUTE
Both at
Sheraton-Cadillac Hotel
Detroit

September, 1954—EIGHTY-NINTH ANNUAL SESSION, MICHIGAN STATE MEDICAL SOCIETY
Sheraton-Cadillac Hotel
Detroit

MICHIGAN STATE MEDICAL SOCIETY

The 88th Annual Session

PANTLIND HOTEL, GRAND RAPIDS, SEPTEMBER 21-22, 1953

Program of Assemblies and Sections

WEDNESDAY MORNING

September 23, 1953

First Assembly

Black and Silver Ballroom, Civic Auditorium, Grand Rapids

Chairman: W. A. HYLAND, M.D., Grand Rapids
Secretary: J. M. WELLMAN, M.D., Lansing

SURGICAL BLOCK

A.M.
9:00 **"The Development and Management of Gastrointestinal Distention"**

WALTER G. MADDOCK, M.D., Chicago, Illinois
Professor of Surgery, Northwestern Medical School; Chairman, Department of Surgery, Wesley Memorial Hospital

9:30 **"The Place of Radioactive Isotopes in Clinical Practice"**

WILLIAM D. HOLDEN, M.D., Cleveland, Ohio
Oliver T. Payne, Professor of Surgery, Western Reserve University School of Medicine; Director of Surgery, University Hospitals of Cleveland

The tremendous amount of activity in research institutions that has centered around the acquisition of information concerning radioactive isotopes has left the practicing physician and surgeon in a state of bewilderment concerning the applicability, usefulness, danger, and cost of isotopes. Knowledge has accumulated at the present time so that it is known that some disease states can be more satisfactorily diagnosed and treated by utilizing certain isotopes. Others that may ultimately be of proven value in clinical practice are still in a stage of experimental development. Some of these problems will be discussed in an attempt to clarify ambiguous concepts concerning the use of radioactive isotopes. The many and varied uses of radioactive iodine in diagnosis and therapy will be discussed.

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"The Treatment of the Severely Burned"**
EVERETT I. EVANS, M.D., Richmond, Virginia
Professor of Surgery and Director, Laboratory for Surgical Research, Medical College of Virginia

11:30 **"Clinical Use of Testosterone"**

FRANK HINMAN, JR., M.D., San Francisco, California
Assistant Clinical Professor of Urology, University of California School of Medicine, San Francisco

The actions of the male sex hormone are plain to see in certain experiments of nature. The boy with a Leydig cell tumor is virile and mature. The girl with congenital adrenal hyperplasia has many male characteristics. Adrenal cortical tumors, too, illustrate effects of large doses of androgens in women. These patients demonstrate also some of the dangers of over-dosage.

Testosterone has many clinical uses. In sterility, its use to suppress spermatogenesis is exploited by waiting for a post-treatment "rebound." For female urethritis, it adds another approach to the therapy of the concomitant senile vaginitis. And of prime value is the use of testosterone as replacement therapy for eunuchoidism and delayed puberty. Even its use in the male climacteric is justified under certain circumstances.

12:00 **END OF FIRST ASSEMBLY**

WEDNESDAY NOON

(No Luncheons)

September 23, 1953

12:00 to 1:00 p.m.

DISCUSSION CONFERENCE

Black and Silver Ballroom, Civic Auditorium

Leader: R. W. BUXTON, M.D., Ann Arbor
Participants: WM. L. BENEDICT, M.D., Rochester, Minn.; O. SPURGEON ENGLISH, M.D., Philadelphia; EVERETT I. EVANS, M.D., Richmond, Virginia; DAVID P. FINLEY, M.D., Omaha, Neb.; FRANK HINMAN, JR., M.D., San Francisco; WILLIAM D. HOLDEN, M.D., Cleveland; WALTER G. MADDOCK, M.D., Chicago; and LEO M. TARAN, M.D., Roslyn, N. Y.

WEDNESDAY AFTERNOON

September 23, 1953

Second Assembly

Black and Silver Ballroom, Civic Auditorium, Grand Rapids

Chairman: H. H. HISCOCK, M.D., Kalamazoo
Secretary: L. L. LODER, M.D., Muskegon

P.M.
2:00 **"Management of Rheumatic Fever and Rheumatic Heart Disease"**
LEO M. TARAN, M.D., Roslyn, Long Island, New York
Medical Director, St. Francis Sanatorium; Consultant Cardiologist, Meadowbrook Hospital; Chief, Children's Cardiac Clinic, King's County Hospital

In recent years it has become clear that the diagnostic criteria of rheumatic fever which have been evolved over the years fall short in adequately describing the disease as we see it at present. This may be explained on the basis of a distinct change in the natural course of this disease or in a wider experience with more sensitive diagnostic means. Experience with large numbers of cases observed under controlled conditions give the unequivocal impression that the fundamental nature

of rheumatic fever is rheumatic carditis; that all other classical manifestations may be superficial and express simply the reaction of the individual patient to the disease.

These observations further teach the clear cut lesson that rheumatic fever and rheumatic heart disease begin much earlier than has been suspected and that the activity lasts much longer than the clinical symptoms would seem to indicate.

Careful evaluation of various therapeutic regimes lead to the conclusion that for the moment there are no specific pharmacological means for altering the course of this disease. In our experience the best approach is meeting basic physiologic demands placed upon the patient by his disease and thus bringing him to a more adequate physiologic economy of adaptation to the disease. Long term sanatorium care with all its implications remains the most constructive way of managing this disease. Salicylates, hormones, and other similar suggestions have a definite place in the pharmacology of rheumatic fever and rheumatic heart disease, but only as a means of "tying over the patient" during the course of the acute explosive stage. Cardiac rest remains the treatment of choice for protracted carditis.

Antihemolytic streptococcal drugs may serve to prevent acute episodes in some rheumatic patients. A large experience with this measure for the prevention of rheumatic onsets or recurrences is being accumulated. The results of this experience will become apparent in the next few years.

2:30 **"Multiple Sclerosis"**

WILLIAM L. BENEDICT, M.D., Rochester, Minnesota

Emeritus Professor of Ophthalmology, University of Minnesota; President, American Ophthalmological Society; Secretary-Treasurer, American Academy of Ophthalmology and Otolaryngology

The ocular symptoms of multiple sclerosis are similar to other affections of the optic nerve trunk and consist of visual loss to a degree proportionate to the severity of the lesion, the rapidity of onset and the length of time it is effective. Differential diagnosis is supported by other local and constitutional findings and the results of biological tests and roentgenograms. In the absence of additional evidence of multiple sclerosis, the visual symptoms are only presumptive of that disease of the nerves as the cause of blindness, and a definite diagnosis may be deferred pending occurrences of other data. However, the history of an episode of blindness brought on by attacks of multiple sclerosis is characteristic and sometimes pathognomonic.

Symptoms similar to those of multiple sclerosis are brought on by retrobulbar neuritis of toxic origin, chronic intracranial inflammations, tumors situated on or near the anterior visual pathways and trauma. The etiology of multiple sclerosis is obscure. The initial changes in the nerve and the stages of pathologic progression are well known, but methods of treatment are controversial. The disease attacks young females predominantly, and about 15 per cent of all cases have ocular symptoms.

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"The Post Cesarean Baby"**

DAVID P. FINDLEY, M.D., Omaha, Nebraska

Assistant Professor of Obstetrics and Gynecology, College of Medicine, University of Nebraska

4:30 **"Treatment of Psychosomatic Illness"**

O. SPURGEON ENGLISH, M.D., Philadelphia, Pennsylvania

Professor and Head of Department of Psychiatry, Temple University Medical School and Hospital

5:00 **END OF SECOND ASSEMBLY**

Program of Sections

WEDNESDAY
September 23, 1953

5:00 to 6:00 p.m.

SECTION ON OPHTHALMOLOGY

Parlor G, Civic Auditorium

Chairman: L. L. LODER, M.D., Muskegon
Secretary: L. F. CARTER, M.D., Detroit

"Orbital Edema"

WILLIAM L. BENEDICT, M.D., Rochester, Minnesota

A number of systemic diseases and some local diseases are accompanied by edema of the orbit. In some instances the edema is present in only moderate amount for a few days or a few weeks. In others it is recurrent, variable, or progressively worse, sometimes resulting in permanent tissue changes.

Coincident edema of the eyelids is quite common and in some cases precedes edema of the orbit or is predominant.

Etiology is not known in some forms of orbital edema; some are metabolic in origin, others due to local or obscure causes.

Diagnosis is not difficult in most cases, but some conditions characterized by orbital edema are not generally recognized in the early stages.

Treatment is directed toward the cause when known. Symptomatic treatment by irradiation, surgery and medicinal agents is recommended for relief from pain and visual impairment.

SECTION ON NERVOUS AND MENTAL DISEASES

Parlors B and C, Civic Auditorium

Chairman: T. V. HOAGLAND, M.D., Detroit
Secretary: K. C. NICKEL, M.D., Grand Rapids

"The Obligations and the Opportunities of the Neuro-Psychiatrist in Public Education"

O. SPURGEON ENGLISH, M.D., Philadelphia

SECTION ON PEDIATRICS

Red Room, Civic Auditorium

Chairman: P. S. BRADSHAW, M.D., Muskegon
Secretary: H. B. ROTHBART, M.D., Detroit

"Nature and Diagnosis of Rheumatic Fever and Rheumatic Heart Disease"

LEO M. TARAN, M.D., Roslyn, N. Y.

SECTION ON SURGERY

Black and Silver Ballroom, Civic Auditorium

Chairman: J. M. WELLMAN, M.D., Lansing
Secretary: C. L. MACCALLUM, M.D., Midland

"Newer Aspects of Parenteral Alimentation in the Postoperative Period"

WILLIAM D. HOLDEN, M.D., Cleveland, Ohio

One of the many unsolved problems in clinical surgery is the maintenance of a satisfactory nutritional state in a surgical patient who has undergone an extensive operative procedure and cannot be fed orally for a prolonged period of time during the postoperative period. This problem is even more difficult in patients who, for any number of reasons, have had an inadequate nutritional intake prior to the operation.

In the past salt and dextrose solutions were given parenterally but the patient could not be provided with adequate amounts of minerals, utilizable nitrogen, and calories. With newer developments and increased knowledge in the field of parenteral alimentation, it is now possible to give amino acids, various electrolytes, vitamins, fructose, and adequate calories in the form of fat emulsions.

A discussion of the effect of some of these factors on the total metabolism of surgical patients will be presented with attention given to the present state of parenteral nutrition.

SECTION ON UROLOGY

Rooms D and E, Civic Auditorium

Chairman: F. B. BICKNELL, M.D., Detroit
Secretary: B. W. DOVITZ, M.D., Detroit

"Renal Injury From Aortography"

FRANK HINMAN, JR., M.D., San Francisco

Seven patients have been studied who showed renal injury after aortography—either by direct trauma to the

kidney by excessive pressure or misdirected needle, or by indirect injury from drug irritation or sensitivity. Certain rules can be applied clinically to avoid these complications.

WEDNESDAY EVENING
September 23, 1953

GENERAL (PUBLIC) MEETING

Black and Silver Ballroom, Civic Auditorium, Grand Rapids

President: R. J. HUBBELL, M.D., Kalamazoo
Secretary: L. FERNALD FOSTER, M.D., Bay City

P.M.

8:30 **OFFICERS' NIGHT—PUBLIC MEETING**

1. **Call to order, announcements and reports of the House of Delegates by L. Fernald Foster, M.D.**
2. **Introduction of President R. J. Hubbell, M.D., followed by President's Annual Address.**
3. **Induction of members into the MSMS "Fifty-Year Club" by President R. J. Hubbell, M.D.**
4. **Address by E. J. McCormick, M.D., Toledo, Ohio, President of American Medical Association.**
   "Organized Medicine — Its Progress and Problems."
5. **Presentation of scrolls.**
6. **Introduction of President-Elect L. W. Hull, M.D., Detroit, and induction of Dr. Hull into office of President of the Michigan State Medical Society by the Retiring President.**
   Response of Dr. Hull.
7. **Introduction of the new President Elect and other newly elected Officers and of the Chairman of The Council, William Bromme, M.D., Detroit.**
8. **Presentation of scroll and Past President's Key to Retiring President Dr. Hubbell by the Chairman of The Council, Dr. Bromme.**

9:15 9. **The Andrew P. Biddle Lecture.**
"World Affairs and Foreign Policy"
United States Senator Homer Ferguson, Detroit (30 minutes)

Andrew P. Biddle, M.D.
(Deceased August 2, 1944)

Patron of Postgraduate Medical Education

10. **Presentation of Biddle Lecture Scroll.**

10:00 11. **Adjournment.**

THURSDAY MORNING
September 24, 1953

Third Assembly

Black and Silver Ballroom, Civic Auditorium, Grand Rapids

Chairman: J. E. LIVESAY, M.D., Flint
Secretary: C. J. WILLIAMS, M.D., Grosse Pointe

GENERAL PRACTICE DAY

A.M.

9:00 **"What Can Bronchoscopy Do for the General Practitioner?"**

CHEVALIER L. JACKSON, M.D., Philadelphia, Pennsylvania

9:30 **"The Crushed Hand"**
MICHAEL L. MASON, M.D., Chicago, Illinois
Professor of Surgery, Northwestern University Medical School

Crushing injuries of the hand present complicated problems both in immediate care and later reparation. To the actual loss of tissue caused by the injury is added extensive devitalizing damage to skin, and other structures which necessitates wide excision. Injuries of this type caused by punch presses, gears, rollers, belts and pulleys, mangles, corn-pickers and other machinery present difficult problems to the surgeon who first sees them and upon whose initial care the ultimate function of the hand depends. A basic plan for evaluating and treating such wounds is of great help and differs only in details from the plan for care of all open wounds. Adequate wound cleansing and excision, closure of the wound with skin by any one or any combination of methods, molding of the hand into the position of function and splinting in this position under a properly applied compression dressing are the essentials of care.

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"Management of Hearing Impairments"**
GEORGE E. SHAMBAUGH, JR., M.D., Chicago, Illinois
Professor of Otolaryngology, Chairman of Department, Northwestern University Medical School

The management of a patient with a hearing impairment begins with the diagnosis of the type of hearing loss and its probable etiology. Correction of the hearing defect where possible by medical or surgical treatment is the next step. Audiologic rehabilitation is the third step in the management of hearing impairments that cannot be improved to the level of useful practical hearing by therapy.

The methods used in diagnosis of hearing losses will be briefly reviewed. The possibilities of medical and surgical restoration of hearing will be illustrated by specific case reports. The methods available for audiologic rehabilitation of incurable hearing losses will be described.

In childhood the majority of mild hearing losses are due to obstruction of the eustachian tubes and are remediable. On the other hand, most children with a severe hearing loss generally have a non-remediable type of nerve involvement.

In middle life the most common cause for progressive hearing impairment is otosclerosis, a condition which is remediable in most cases by the fenestration operation. The indications for and limitations of this procedure will be described.

Beyond the age of sixty, a nerve type of loss, termed presbyacusis causes a gradually progressive loss of hearing that cannot be improved by therapy.

11:30 **"Patients Are People—A Physician Soliloquy"**
BLAIR HOLCOMB, M.D., Portland, Oregon
Clinical Professor of Medicine, University of Oregon Medical School

As one contemplates the practice of medicine today from the vantage point of thirty odd years of experience, certain impressions stand out in one's mind. And, in a contemplative mood, perhaps it is only natural to take a philosophical rather than a technical viewpoint. Indeed, it may be, that in the fantastic speed of advance of medical knowledge, a sense approaching bewilderment comes to the older physician. It may be that a feeling of inadequacy to keep abreast of technical advances in medicine, influences his thinking. He, perforce, develops

a detached, philosophical approach to the practice of medicine. Unquestionably, this approach is engendered by his experience with people rather than with things. As I say these words to you, I am sure you realize that I am reflecting my own experience and thinking as a physician. More and more throughout the past fifteen years I have spent a greater proportion of my working hours with the patient as a person than I have devoted to the consideration of his disease. This relative preoccupation with the individual, I am sure, has not detracted from his technical care. Rather, I am just as certain, it has enhanced it.

With these frank confessions as a background, perhaps I may be pardoned if I express dogmatically some of my observations and convictions about medicine as we practice it today.

12:00 **END OF THIRD ASSEMBLY**

THURSDAY NOON

(No Luncheons)

September 24, 1953

12:00 to 1:00 p.m.

DISCUSSION CONFERENCE

Black and Silver Ballroom, Civic Auditorium

Leader: ARCH WALLS, M.D., Detroit
Participants: J. A. BARGEN, M.D., Rochester, Minnesota; ALLAN C. BARNES, M.D., Cleveland; ARTHUR T. HERTIG, M.D., Boston; BLAIR HOLCOMB, M.D., Portland, Ore.; CHEVALIER L. JACKSON, M.D., Philadelphia; LOUIS A. M. KRAUSE, M.D., Baltimore; MICHAEL L. MASON, M.D., Chicago; VICTOR A. NAJJAR, M.D., Baltimore; HARRISON SADLER, M.D., Grosse Pte. Farms, Michigan; and GEORGE E. SHAMBAUGH, JR., M.D., Chicago.

THURSDAY AFTERNOON

September 24, 1953

Fourth Assembly

Black and Silver Ballroom, Civic Auditorium, Grand Rapids

Chairman: F. H. DRUMMOND, M.D., Kawkawlin
Secretary: J. P. OTTAWAY, M.D., Detroit

P.M.

2:00 **"Management of the Infertile Couple"**
ALLAN C. BARNES, M.D., Cleveland, Ohio

2:30 **"Genesis of Uterine Cancer, Cervical and Endometrial"**

ARTHUR T. HERTIG, M.D., Boston, Massachusetts

Shattuck Professor of Pathological Anatomy, Head of Department of Pathology, Harvard Medical School.

Carcinoma *in situ* of the cervix uteri is apparently the precursor of invasive cervical carcinoma as suggested by: (1) its incidence, (2) its earlier appearance, (3) its comparably lower incidence in Jewish women, (4) cases which have progressed from carcinoma *in situ* to invasive carcinoma, (5) increasing correlation with the vaginal smear as the lesion progresses to cancer, (6) morphologic *in situ* pattern at margin of invasive cancer, (7) similar light absorption data from sections of *in situ* and invasive carcinoma.

Reference: Hertig, A. T., and Younge, P. A.: Am. J. Obst. & Gynec., 64:807, 1952.

Of 500 cases of endometrial carcinoma, thirty-two cases had tissue taken one to twenty-three years prior to diagnosis. Only such endometrium taken one to fifteen years before was, however, abnormal. Such abnormalities included endometrial polypi, cystic hyperplasia, adenomatous hyperplasia, anaplasia and finally carcinoma *in situ*. In general, the later stages of these progressive changes became more frequent as the time interval shortened between prior biopsy and the diagnosis of cancer. The thirty-two cases, when they developed carcinoma, had an age range, histological appearance and mortality comparable to the entire group of 500 cases of endometrial carcinoma.

Reference: Hertig, A. T., and Sommers, S. C.: Cancer, 2:946-956, 1949.

3:00 **INTERMISSION TO VIEW EXHIBITS**

4:00 **"The Problems of Jaundice in Infancy and Childhood"**

VICTOR A. NAJJAR, M.D., Baltimore, Maryland
Associate Professor of Pediatrics, Johns Hopkins Hospital

1. The causes of jaundice in infancy and childhood will be discussed including a new entity recently described in the newborn "Congenital Familial Nonhemolytic Jaundice with Kernikterus."
2. The anatomical and physiological causes will be correlated with reference to the types of bilirubin found in the serum.
3. The symptomatology of the various types of jaundice will be reviewed.
4. The physiological aspects of bilirubin excretion and clearance through the liver will be shown.

4:30 **"Physical Examination"**
LOUIS A. M. KRAUSE, M.D., Baltimore, Maryland
Professor of Clinical Medicine, University of Maryland Medical School; Chief of Medicine, Lutheran Hospital and City Hospitals, Baltimore

5:00 **END OF FOURTH ASSEMBLY**

——Program of Sections——

THURSDAY

September 24, 1953

5:00 to 6:00 p.m.

SECTION ON OTOLARYNGOLOGY
Room G, Civic Auditorium

Chairman: F. A. LAMBERSON, M.D., Detroit
Secretary: R. B. FAST, M.D., Kalamazoo

"Mechanics of Hearing as Related to Therapy"
GEORGE E. SHAMBAUGH, M.D., Chicago

Roughly, half of the patients that consult us because of a hearing impairment have a conductive type of loss, and half have a pure perceptive loss. As a general rule, most conductive losses can be helped by therapy, whereas perceptive losses cannot be improved by any form of medical or surgical treatment. The only exception to this are the rare cases of psychogenic deafness and the more common condition of labyrinthine hydrops, which in its early stages may respond to medical treatment.

An appreciation of the mechanics of the sound conducting impedence-matching apparatus of the middle ear, permits the application of techniques for the improvement of hearing in various types of conductive losses.

Congenital anomalies of the sound conducting system may be corrected with a very good improvement in hearing by constructing a new impedence-matching mechanism. Depending upon the deformity that is found, a full thickness skin graft is placed in contact with the stapes as a substitute tympanic membrane, or if the stapes is found to be ankylosed, a fenestra is made in the horizontal sub-circular canal. Perforations of the tympanic membrane may be closed with the restoration of normal hearing.

Occlusion of the eustachian tube with secretory otitis nearly always responds with appropriate therapy. Many of these cases are associated with a chronic nasal allergy and clear up only after allergic management.

Adhesive otitis, the result of a previous microtic otitis media, can be helped by construction of a new tympanic cavity and substitute tympanic membrane with fenestration of the labyrinth when the stapes is found to be fixed.

Stapes fixation due to otosclerosis can be helped by fenestration. An appreciation of the mechanics of the fenestrated ear permits us to predict the improvement to be expected from operation in a particular case. The mechanics of the fenestrated ear may be improved further by the use of anaquaphor prosthesis which frequently gives a 5 to 10 decibel added improvement in hearing for the speech frequencies, resulting in a very gratifying final level of hearing.

SECTION ON GENERAL PRACTICE

Black and Silver Ballroom, Civic Auditorium

Chairman: C. J. WILLIAMS, M.D., Grosse Pointe
Secretary: J. W. RICE, M.D., Jackson

"The Necessity of Illness"

HARRISON SADLER, M.D., Grosse Pointe Farms

Associate Professor of Psychiatry, Wayne University College of Medicine

SECTION ON OBSTETRICS AND GYNECOLOGY

Red Room, Civic Auditorium

Chairman: J. P. OTTAWAY, M.D., Detroit
Secretary: J. L. GILLARD, M.D., Muskegon

"Cancer of the Cervix"

ALLAN C. BARNES, M. D., Cleveland

SECTION ON GASTROENTEROLOGY AND PROCTOLOGY

Rooms B and C, Civic Auditorium

Chairman: R. L. FITTS, M.D., Grand Rapids
Secretary: R. M. BURKE, M.D., Detroit

"The Management of Iliocolitis"

J. A. BARGEN, M.D., Rochester, Minnesota

The differential diagnosis of some of the common forms of ulcerative colitis and ileitis will be discussed, including regional ileitis, amebiasis, segmental and diffuse ulcerative colitis. The important diagnostic laboratory data will be stressed. A suitable program of treatment will be outlined for each of these conditions.

THURSDAY EVENING

September 24, 1953

STATE SOCIETY NIGHT

Ballroom, Pantlind Hotel

P.M.
10:30 **An evening of entertainment for all registrants, their ladies and guests.**

Cabaret-style Dance and Floor Show
Host: Michigan State Medical Society
(Admission by card furnished to all upon registration)

ONLY ONE MORE DAY TO VISIT YOUR MANY FRIENDS IN THE EXHIBIT

FRIDAY MORNING

September 25, 1953

Fifth Assembly

Black and Silver Ballroom, Civic Auditorium, Grand Rapids

Chairman: J. D. MILLER, M.D., Grand Rapids
Secretary: F. A. LAMBERSON, M.D., Detroit

A.M.
9:00 **Beaumont Lecture**
"Problems of Nutrition in Ulcerative Disease of the Digestive Tract"

J. A. BARGEN, M.D., Rochester, Minnesota

Professor of Medicine, Mayo Foundation; Chief of Department of Gastroenterology, Mayo Clinic

The fundamental concepts of the origin and inception of ulcerative disease of the stomach and intestine will be outlined. The effect of long-standing ulcerative disease on the human bodily economy will be detailed. The development of various nutritional disturbances and the problems of combating these will be described. More detailed discussion of the various disorders of nutrition and metabolism associated with ulcerative disease of the digestive tract will be stressed, together with suggestions for their correction.

9:30 **"Oral and Cutaneous Clues in Medicine and Surgery"**

JOHN G. DOWNING, M.D., Boston, Massachusetts

Professor Emeritus, Dermatology at Tufts College Medical School and Boston University.

Look and learn! Many diseases may be misdiagnosed, not because the physician does not know, but because he does not look at the patient thoroughly. This is true not only in the field of internal medicine, but also in surgery and the various specialties such as eye and ear, nose and throat. Even the pathologist can be helped in his final diagnosis by observing the clinical lesion. Careful observation of the patient, his mucous membranes and skin will often supply valuable clues for diagnosis. Frequently the first sign of a systemic disease may be seen by the dentist on the oral mucous membrane. Many systemic diseases start with a mild eruption on the skin. In these days of multiple drug therapy it is very important that the physician be able to differentiate between eruptions caused by drugs and those due to systemic diseases. The surgeon should have a knowledge of the cutaneous lesions which are physical signs of important abdominal disturbances. The obstetrician should be cognizant of the various cutaneous eruptions that complicate pregnancy. The internist should recognize the various pigment changes that occur on the skin from nutritional and metabolic disturbances. The hematologist should know the various cutaneous lesions which often accompany blood dyscrasias. The cardiologist should not discard the suggestive skin lesions which may appear before corroboration can be made by the stethoscope or electrocardiogram. Finally, the dermatologist should be cognizant of the various cutaneous symptoms and signs which should prompt him to co-operate with other clinicians working in the various fields of medicine.

10:00 **INTERMISSION TO VIEW EXHIBITS**

11:00 **"Hepatography—The Roentgen Examination Of the Liver"**

LEO G. RIGLER, M.D., Minneapolis, Minnesota

Professor and Chief of Department of Radiology, University of Minnesota Medical School, Minneapolis

11:30 **"An Evaluation of the Grand Rapids Water Fluoridation Supply"**

JOHN W. KNUTSON, D.D.S., Washington, D. C.

Assistant Surgeon General, Chief Dental Officer, Public Health Service

12:00 **END OF FIFTH ASSEMBLY**

FRIDAY NOON

(No Luncheons)

September 25, 1953

12:00 to 1:00 p.m.

DISCUSSION CONFERENCE

Black and Silver Ballroom, Civic Auditorium

Leader: A. A. HUMPHREY, M.D., Battle Creek

Participants: J. A. BARGEN, M.D., Rochester, Minnesota; JOHN G. DOWNING, M.D., Boston; LESLIE N. GAY, M.D., Baltimore, Maryland; JULIAN JOHNSON, M.D., Philadelphia; PAUL R. CANNON, M.D., Chicago; NORMAN M. KEITH, M.D., Rochester, Minn.; JOHN W. KNUTSON, D.D.S., Washington, D. C.; HAROLD J. MAGNUSON, M.D., Chapel Hill, North Carolina; LEO G. RIGLER, M.D., Minneapolis, Minnesota.

FRIDAY AFTERNOON

September 25, 1953

Sixth Assembly

Black and Silver Ballroom, Civic Auditorium, Grand Rapids

Chairman: R. J. HUBBELL, M.D., Kalamazoo

Secretary: M. G. BUTLER, M.D., Saginaw

P.M.

2:00 "Successes and Failures in Relation to the Problem of Parenteral Alimentation"

PAUL R. CANNON, M.D., Chicago, Illinois

Professor of Pathology, Chairman, Department of Pathology, University of Chicago

The important advances in the field of parenteral alimentation include the wider use of whole blood, plasma, serum albumin, protein hydrolysates, vitamin solutions, and a better understanding of the importance of proper electrolyte solutions, notably those containing potassium. As a result, the preoperative and postoperative care of patients has been materially improved.

Before a completely adequate parenteral alimentation is achieved, however, several obstacles must be overcome. For example, the big problem of caloric adequacy remains, despite the increasing use of glucose solutions as well as solutions containing fructose and alcohol. Fat emulsions suitable for intravenous use are now feasible, but difficulties in their keeping qualities make them unsuitable for general use. Balanced salt solutions have been developed for particular purposes but their use is still limited. The problem of homologous serum jaundice still remains to limit the usefulness of plasma. Above all, there is still too much complacency in relation to the fullest use of information and materials now available. Discussion will be directed at the over-all problem.

2:30 "The Interpretation of Positive Serologic Tests For Syphilis in Clinically Negative Patients"

HAROLD J. MAGNUSON, M.D., Chapel Hill, North Carolina

Director, Venereal Disease Experimental Laboratory, U.S.P.H.S.; Research Professor Experimental Medicine, University of North Carolina, Chapel Hill, North Carolina.

During recent years there has been increasing concern on the part of the physician in the interpretation of positive serologic tests for syphilis in the clinically negative patient. At least three factors have contributed to this concern. The widespread use of mass serologic testing procedures on presumably healthy individuals, either on a voluntary basis or as part of legal requirements, has increased the number of persons falling into the above category. Secondly, the recent declines in the incidence of syphilis in the United States have given rise to a relative increase in the proportion of biologic false positive reactors in any group of persons with positive serologic tests. Third, recent laboratory developments in the serodiagnosis of syphilis and the publicity attendant to their discovery have served to emphasize, perhaps unduly, the size of the biologic false positive reactor problem.

While the ultimate decision as to whether the patient has syphilis must rest on the careful synthesis of all clinical and laboratory findings, newer developments in the laboratory field can be of considerable assistance in this evaluation. The evaluation of these procedures, their clinical interpretation, and a consideration of their present status and probable future will be presented.

3:00 FINAL INTERMISSION TO VIEW EXHIBITS

3:30 "Some Important Factors in the Treatment of Edema"

NORMAN M. KEITH, M.D., Rochester, Minnesota

Professor of Medicine, Emeritus, University of Minnesota; Consultant in Medicine, Emeritus, Mayo Clinic

During the last thirty (30) years the application of accurate microchemical and microphysical methods has added much useful knowledge to the problem of edema. Some of the facts disclosed have facilitated the physician's ability to treat successfully certain types of edema. On the contrary, other results of clinical research indicate the complexity of the conditions sometimes encountered. These latter have become more numerous, in part because of more frequent application of newer antiedemic therapy and as a result, prolongation of life.

Low salt diets occupy an important place in the treatment of edema. However, these may cause hyponatremia and hypochloremia and a liberal intake of sodium chloride may sometimes be necessary for the initiation of diuresis. The actual intake of water may also be important.

The diuretics chiefly employed are derivatives of organic mercury, acid salts, potassium salts and xanthine compounds. Certain substances that expand the plasma, for example, normal blood plasma, serum albumin, acacia or dextran may give rise to diuresis. In the use of these therapeutic agents, the physician must remember that they may not only remove excessive body fluids, but possibly other substances that are necessary for healthy metabolism. Thus tissue replacement may become a therapeutic problem.

This introduction of cortisone and corticotropin to the therapy of nephritic and nephrotic edema has added a new chapter to the study of edema. In some patients these hormones caused diuresis, while in others the changes in metabolism has been significant.

4:00 "The Dramatic Story of Dramamine"

LESLIE N. GAY, M.D., Baltimore, Maryland

Professor of Medicine, Johns Hopkins University School of Medicine.

4:30 "The Present Status of the Surgery of Mitral and Aortic Stenosis"

JULIAN JOHNSON, M.D., Philadelphia, Pennsylvania

Professor of Surgery of the School of Medicine and Graduate School of Medicine, University of Pennsylvania

The experience gained with more than 100 consecutive operations for mitral stenosis will be reported. Emphasis will be placed upon the use of the angiocardiogram in the selection of patients. As far as we know, the angiocardiogram was first used for this purpose in our clinic. Its virtues will be discussed.

The preoperative preparation and the anesthetic management are extremely important and will be presented in some detail.

The experience in this series has been that while finger fracture alone is often satisfactory, it has been necessary to use a cutting instrument in almost half of the patients. In certain patients it has not been possible to open the commissure entirely out to the heart wall by the use of the finger along.

The result of the operation can be predicted reasonably accurately by the increase in the mitral opening obtained by the surgeon. The vast majority of the patients have been greatly improved. The mortality has been reduced from an early figure of about 20 per cent to the present one of 5 per cent. The complications and results of the procedure will be reported in detail.

A dilating instrument is now available to open the stenotic aortic valve. Ten patients have now been operated upon by us with one death. It appears to be a very promising method. The results of its use will be presented.

5:00 **END OF SIXTH ASSEMBLY**

—Program of Sections—

FRIDAY

September 25, 1953

5:00 to 6:00 p.m.

SECTION ON RADIOLOGY

Rooms B and C, Civic Auditorium

Chairman: F. K. Wietersen, M.D., Birmingham

"Vascular Disturbances of the Lungs"

Leo G. Rigler, M.D., Minneapolis, Minnesota

SECTION ON DERMATOLOGY AND SYPHILOLOGY

Red Room, Civic Auditorium

Chairman: M. G. Butler, M.D., Saginaw
Secretary: C. J. Courville, M.D., Detroit

"Hand Affections—A Diagnostic, Therapeutic, Economic, and Rehabilitation Problem"

John G. Downing, M.D., Boston, Massachusetts

It has often been remarked that a severe cutaneous eruption of the hands is more discomforting and disabling than a broken limb. This fact has in the past 20 years been thoroughly realized by insurers who find that hand affections have cost them many millions of dollars. It is recognized by labor also who realize it has cost numerous hours of loss of manpower. Mistakes in diagnosis have also been expensive, inasmuch as a physician is apt to fail to differentiate between diseases caused by external factors from those diseases of the hands caused by systemic disturbances. No satisfactory therapeutic regime has been outlined for such affections. Lastly, there is no rehabilitation plan to try to restore the patient afflicted by traumatic injuries of the hands to a useful position in his future economic existence. An attempt will be made to briefly summarize the various cutaneous affections involving the hands, and to outline some suggestions as to therapy and prevention of further disabilities. Illustrations will be shown of certain types of dermatitides including dermatitis factitia and systemic diseases difficult to differentiate from dermatitides due to external factors.

SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE

Rooms D and E, Civic Auditorium

Chairman: J. G. Molner, M.D., Detroit
Secretary: C. A. Neafie, M.D., Pontiac

"Fluorides and Dental Health"

John W. Knutson, D.D.S., Washington, D. C.

SECTION ON PATHOLOGY

Continental Room, Pantlind Hotel

Chairman: W. A. Stryker, M.D., Wyandotte

(See announcement of meeting of Michigan Pathological Society)

SECTION ON MEDICINE

Black and Silver Ballroom, Civic Auditorium

Chairman: D. R. Boyd, M.D., Muskegon
Secretary: C. K. Stroup, M.D., Flint

Title to be Announced

Leslie N. Gay, M.D., Baltimore, Maryland

6:00 **END OF SCIENTIFIC ASSEMBLY AND OF THE 1953 ANNUAL SESSION**

HOTEL RESERVATIONS

MICHIGAN STATE MEDICAL SOCIETY

88th Annual Session

Grand Rapids, September 21 to 25, 1953

The reservation blank below is for your convenience in making your hotel reservations in Grand Rapids. Please send your application to L. E. Ames, Secretary, Committee on Hotels for MSMS Convention, Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Committee on Hotels by sharing a room with another registrant, when convenient.

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L. E. Ames, Secretary,
Committee on Hotels, MSMS Convention,
c/o Pantlind Hotel
Grand Rapids, Michigan

Please make hotel reservation(s) as indicated below:

.....Single Room(s)

.....Double Room(s) for.....persons

.....Twin-Bedded Room(s) for.....persons

Arriving September.....hour.....A.M.....P.M.

Leaving September.....hour.....A.M.....P.M.

Hotel of First Choice:.....

Second Choice:.....

Names and addresses of all applicants including person making reservation:

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Date..... Signature.....

Address..... City.....

Scientific Exhibits

American Medical Association **Booth Nos. I, II, III**
Chicago, Illinois

"Your Medical Care"

This exhibit is composed of seven separate units using three-dimensional carved figures portraying suggested programs of the American Medical Association to make medical care more readily available to all persons.

American College of Surgeons Trauma Committee
Grand Rapids Chapter **Booth No. IV**

"Trauma to the Chest"

Cook County Hospital (Walter J. Reich, M.D.)
Chicago, Illinois **Booth No. V**

"Abnormal Bleeding in Gynecology"

Detroit Cancer Center **Booth No. VI**
Detroit, Michigan

"Activities of the Detroit Cancer Center"

Exhibit portrays the Detroit Cancer Center program of lay and professional education; fundamental, clinical, and statistical research; services to patients and physicians; cancer detection examinations; fund-raising to support these activities; carried on by the American Cancer Society Southeastern Michigan Division, Detroit Institute of Cancer Research, Yates Memorial Clinic and Michigan Tumor Registry.

MSMS Cancer Control Committee and **Booth No. VII**
Michigan Division, American Cancer Society

"Cancer of the Colon and Rectum"

Presents statistics, etiology, pathology, diagnosis, treatment and after-care of colostomies. Also rubber models with viewing instruments for observation of lesions. Kodachrome slides show early malignant lesions. Delay in diagnosis is emphasized.

MSMS Rheumatic Fever Control **Booth No. VIII**
Program and Michigan Heart Association

"The MSMS Rheumatic Fever Control Program"

Charts and graphs concerning the Diagnosis, Treatment and Prevention of rheumatic fever and rheumatic heart disease and the Rheumatic Fever Control Program of the Michigan State Medical Society. The exhibit will feature a demonstration of the Cardioscope; Stethographic recordings by Franklin D. Johnston, M.D., University of Michigan Medical School, and by J. Scott Butterworth, M.D., N. Y. U. Postgraduate Medical School will be presented.

Michigan Heart Association **Booth No. IX**

"The Mechanical Heart Acclaimed One of the Top Ten Scientific Developments of 1952."

Exhibit consists of three panels showing the actual mechanical heart in operation. It also depicts the methods of cannulation for double-sided substitution of the heart plus an "exploded" view of all parts which come in contact with the blood.

Wayne University College of Medicine **Booth No. X**
and Wayne County General Hospital

"Obstetrical Shock of Abruptio Placentae"

During abruptio placentae conditions are favorable for autoextraction of decidual juices and debris into the maternal circulation. These materials may initiate widespread intravascular coagulation. This may jeopardize the very existence of the individual not only by depletion of coagulation mechanisms but by occluding the pulmonary circulation, thereby causing "obstetrical shock."

Michigan Department of Health **Booth No. XI**
Lansing, Michigan

"Simple Goiter and Iodized Salt"

Michigan's dramatic conquest of endemic goiter within the past thirty years is shown by photographs and diagrams, from the initial survey of school children in 1923 revealing 47.2 per cent with thyroid enlargement, through the introduction of iodized salt in 1924, to the survey in 1951 with its amazing drop in goiter to 1.4 per cent.

Michigan Pathological Society **Booth No. XII**

Michigan Crippled Children Commission **Booth No. XIII**

Allergy Clinic, Harper Hospital **Booth No. XIV**
Detroit, Michigan

"Patterns in Contact Dermatitis"

Attention to the pattern of a dermatitis can often establish the causative diagnosis and produce a cure.

MSMS Public Relations **Booth No. XV**

"Medical Associates and the screening of medical motion pictures"

An example of the type of exhibits available to County Medical Societies for local exhibitions, state and county fairs. The purpose of the exhibit is to acquaint MSMS members with what they might receive in answer to requests to MSMS and AMA for exhibits to be placed by local medical societies before local gatherings.

American Academy of General Practice **Booth No. XVI**
Kansas City, Missouri

Michigan Tuberculosis Association **Booth No. XVII**
Lansing, Michigan

"The Practicing Physician and Tuberculosis Control"
Exhibit points up the extent of the problem in tuberculosis control, the part played by the practicing physician in case-finding, and the role of drugs in treatment as well as what can be expected from drugs.

Wayne University Alumni Association **Booth No. XVIII**
Detroit, Michigan

Detroit Society for the Prevention of **Booth No. XIX**
Blindness and Grand Rapids Association for the
Blind and for Sight Conservation

"Preventive Ophthalmology"

This exhibit described the role of many medical specialists in the prevention of blindness. Exhibit prepared by Isadore Givner, M.D., and Bernard Kronenberg, M.D., ophthalmologists of New York City.

Michigan Chapter **Booth No. XX**
Arthritis and Rheumatism Foundation

National Foundation for Infantile Paralysis
New York, New York **Booth No. XXI**

"Isolation Techniques and Nursing Care in Poliomyelitis"

The exhibit presents in graphic form reasons for isolation in poliomyelitis, method of setting up an isolation unit, isolation nursing techniques and nursing care of the respirator patient.

Technical Exhibits

Abbott Laboratories **Booth No. D-16**
North Chicago, Illinois

Abbott will display SULESTREX® Piperazine tablets for the control of symptoms of the climacteric. SULESTREX is a pure, odorless and tasteless compound which is rapidly hydrolyzed in the body. It provides rapid control of menopausal symptoms with an extremely low incidence of side-effects. SULESTREX is absolutely pure, crystalline estrogen, chemically standardized for unvarying hormonal activity. Because SULESTREX is absolutely pure, it can never impart an odor to the breath or perspiration. The pure inorganic salts of estrone sulfate are combined with piperazine to form a stable, water-soluble, crystalline salt. It is as effective estrogen therapy as it is presently possible to prescribe.

Alkalol Company **Booth No. C-13**
Taunton, Massachusetts

The Alkalol Company, Taunton, Massachusetts, will feature Alkalol, the balanced, alkaline, saline solution for the treatment of mucous membranes and irritated tissues. It is bland, non-toxic, and effective, and has been a favorite since 1896. We are also showing Irrigol, a powder which in solution makes an aseptic, slightly astringent vaginal douche. It is widely used also for colonic irrigations and as an effective rectal enema.

A. S. Aloe Company **Booth No. D-10**
St. Louis, Missouri

Visit Booth D-10 where the Aloe representative will show you a cross section of the complete line of physicians' equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Steeline—tomorrow's treatment room furniture today—featuring the body contour table top, magnectic door catches, and advanced design all in new decorators' colors.

American Hospital Supply Corporation **Booth No. C-19**
Evanston, Illinois

American Hospital Supply Corporation will have on display the complete line of Baxter intravenous solutions and accessory sets, including the new electrolyte solutions. Also on display will be Gentran, an effective, proven plasma volume expander for use in the treatment of shock.

Ames Company, Inc. **Booth No. B-15**
Elkhart, Indiana

APAMIDE—prescription analgesic—antipyretic (N-acetyl-p-aminophenol) of rapid and prolonged action, inherently well-tolerated.

APROMAL — non-narcotic, non-barbiturate sedative (acetylcarbromal) plus N-acetyl-p-aminophenol. Because it has virtually no hypnotic effect APROMAL may be prescribed for daytime use.

DECHOLIN with Belladonna will be shown as potent aid in treatment of several frequently occurring types of biliary dysfunction.

Armour Laboratories **Booth No. A-13**
Chicago, Illinois

Ayerst, McKenna & Harrison, Ltd. **Booth No. D-15**
New York, New York

You are cordially invited to visit Booth No. D-15 to see our exhibit which features "Thiosulfil," "Trilene" and "Deravine." Our representatives welcome this opportunity to answer any inquiries you may have relative to any of the products in our line of prescription specialties. Descriptive literature, reprints, and samples are available to physicians.

Baby Development Clinic **Booth No. F-3**
Chicago, Illinois

To aid Maternity Patients demonstration samples and literature concerning carefully selected supportive brassieres and sashes. Demonstration material on feeding including Evenflo bottles, nipples and brushless cleanser. Manual: simple, direct, cheerful, authoritative, helps parents prepare for coming baby. Film strips, slides and outlines for parents' classes.

Baker Laboratories, Inc. **Booth No. C-18**
Cleveland, Ohio

You are cordially invited to visit the Baker display where you will see beautiful translite pictures of Wisconsin Grade A Farms and the Baker's milk processing laboratories.

Medical service representatives will be glad to discuss with you the clinical application of Baker's Modified Milk and Varamel, two outstanding products that are making new progress in successful infant feeding.

Bard-Parker Company, Inc. **Booth No. C-17**
Danbury, Connecticut

"In a matter of seconds" . . . Rib-Back surgical blades ready for sterilization! The new B-P RACK-PACK saves time and labor in the O.R. . . . protects against costly accidental damage to sharp edges. Also knife handles, B-P Germicide, Chlorophenyl, sterilizing containers, transfer forceps and The Reese Dermatome.

Barry Laboratories, Inc. **Booth No. C-7**
Detroit, Michigan

The BARRY LABORATORIES exhibit will display the newest and most up-to-date allergy materials for diagnosis and treatment. Also on display will be their newly released germicidal concentrate, Merphene, for the cold sterilization of surgical instruments, as well as a complete line of injectables. An attendant will be available to answer questions.

Becton, Dickinson and Company **Booth No. E-18**
Rutherford, New Jersey

Becton, Dickinson and Company invites you to see the new Multifit Syringe—every plunger fits every barrel. Also on display, Yale Syringe and Needle Cleaner, Diagnostic Equipment, Ace and Asepto Bandages, Blood Collection Equipment, Thermometers and allied products.

Beech-Nut Packing Company **Booth No. A-10**
New York, New York

The Beech-Nut cereals will be displayed in the new 4-ounce size package. This innovation is a convenience to doctors and mothers both. Nutritionists will be in attendance at the booth to answer questions about the newer products as well as the complete line of Beech-Nut Strained and Junior Foods.

The Borden Company **Booth No. F-11**
New York, New York

The very latest in infant nutrition is available to you at the Borden booth No. F-11. Ask about BREMIL, MULL-SOY, DRYCO, and BIOLAC.

Brooks Appliance Company **Booth No. D-17**
Chicago, Illinois

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated Primer plus the Elastic Adhesive Dalzoflex which are used in treating leg ulcers and phlebitis. The Nulast Elastic Crepe Bandages, Elastic Stockings and Surgical Instruments will also be displayed.

Brown & Williamson Tobacco Corporation **Booth No. E-15**
Louisville, Kentucky

VICEROY

The exclusive Health-Guard Filter Tip on VICEROY King Size Cigarettes provides important protection to smokers. A demonstration and explanation of its unique advantages will be of interest to all.

Burroughs Wellcome & Company (U.S.A.) Inc. **Booth**
Tuckahoe, New York **No. D-2**

AEROSPORIN®* OTIC SOLUTION. Sterile. Antimicrobial, especially against Pseudomonas aeruginosa. Hygroscopic-acid pH. *Aerosporin® Sulfate Polymyxin B Sulfate.
POLYSPORIN® Polymyxin B-Bacitracin ointment. Broad spectrum antibacterial action. Rarely sensitizes—Resistance rarely develops.

Camel Cigarettes **Booth Nos. A-15, A-16**
New York, New York

CAMEL Cigarettes will mark your initials on an attractive plastic cigarette case filled with a package of those mild, flavorful CAMELS. This exhibit features a display of some of the tobaccos used in blending this famous cigarette which outsells all other brands by many billions of cigarettes per year.

S. H. Camp & Company **Booth No. D-1**
Jackson, Michigan

S. H. Camp and Company cordially invites you to see the new Camp Plastica Orthopraxis Appliances, Cervical, Taylor and Goldthwait type braces. Inspect the latest development in supports for Pneumoperitoneum Treatment of Pulmonary Tuberculosis as well as Diaphragmatic Supports for Symptomatic Treatment of Pulmonary Emphysema. The Camp-Varco Pelvic Traction Belt is growing in acceptance and has been found increasingly useful in cases of low back syndrome. Let our representative show this to you along with the new rib fracture belts of laminated foam rubber and cloth.

Carnation Company **Booth No. B-14**
Los Angeles, California

The Carnation Company cordially invites you to visit Booth B-14 where you will see a series of translites on our canning and sterilization process. Carnation Medical Specialists will explain our sole processing and give you reasons why Carnation Milk deserves consideration as your first choice in infant feeding formulas.

Chicago Pharmacal Company **Booth No. E-10**
Chicago, Illinois

The Chicago Pharmacal Company (Chimedic) welcomes your visit to our booth, which features the following specialties: URISED, nationally known antiseptic and sedative tablet for all types of genito-urinary infections; TOLYPHY, the new improved muscle relaxant in both tablet and liquid form, which combines the full therapeutic dosage of mephenesin with physostigmine and atropine; plus a complete injectable line, featuring Council-accepted a-Estradiol and BEXII-M (1000 mcgm. B 12 Crystalline, U.S.P. per cc.).

Ciba Pharmaceutical Products, Inc. **Booth No. C-10**
Summit, New Jersey

Ciba's exhibit (Booth C-10) features two new agents for more effective management of hypertensive disorders—REGITINE, for simple and accurate diagnosis of hypertension produced by pheochromocytoma —APRESOLINE, an agent of choice for gradual sustained lowering of blood pressure.
You are invited to visit the Ciba booth for literature on APRESOLINE and REGITINE.

Coca-Cola Company **Booth Nos. A-18, A-19**
Atlanta, Georgia

Ice cold Coca-Cola served through the courtesy and cooperation of the LaSalle Coca-Cola Bottling Co. and The Coca-Cola Company.

DePuy Manufacturing Company **Booth No. A-23**
Warsaw, Indiana

De Puy Manufacturing Company, Inc., will feature the new mechanical bed jack that is trouble free, new improved Plymale Lift Frame, and many other new fracture and orthopedic appliances.

Desitin Chemical Company **Booth No. C-15**
Providence, Rhode Island

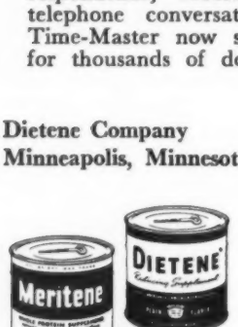
DESITIN OINTMENT: the pioneer in external cod liver oil therapy.
Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids and fissures.
DESITIN POWDER: a unique, dainty medicinal powder saturated with cod liver oil.
DESITIN HEMORRHOIDAL SUPPOSITORIES with COD LIVER OIL: coats ano-rectal area with soothing, lubricating cod liver oil, gives prompt relief of pain, allays itching.
DESITIN LOTION: the original cod liver oil lotion, soothing, protective, mildly astringent and healing, in non-specific dermatitis, pruritus, poison ivy, et cetera.

Dictaphone Corporation **Booth No. B-11**
Detroit, Michigan

A way to gain extra time is on demonstration at the Dictaphone Booth. It's the new electronic Dicta-

phone Time-Master dictating machine used the world over by physicians to dictate case histories and correspondence, record interviews, consultations and telephone conversations. Completely portable, the Time-Master now saves valuable hours every week for thousands of doctors and their nurse assistants.

Dietene Company **Booth No. B-7**
Minneapolis, Minnesota



Visit our exhibit and examine the Free Diet Service for physicians. The diets are nutritionally well-balanced, easy to follow and made to appear as if they were typed in your office.
MERITENE, the economical and palatable whole protein supplement and DIETENE, the "Council-Accepted" reducing supplement will be on display.

Doho Chemical Corporation **Booth No. B-3**
New York, New York

Doho Chemical Corporation is pleased to exhibit AURALGAN, the ear medication for the relief of pain in Otitis Media and removal of Cerumen; RHINALGAN, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged; and the NEW OTOSMOSAN, the effective, non-toxic ear medication which is Fungicidal and Bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears. Mallon Chemical Corporation, subsidiary of the Doho Chemical Corporation, is also featuring RECTALGAN, the liquid topical anesthesia, also Bactericidal and Fungicidal for control of secondary invaders, particularly recommended for treatment of mold infections (monilia) occurring after anti-biotic therapy; also for relief of pain and discomforture in hemorrhoids, pruritus and perineal suturing.

Eaton Laboratories, Inc. **Booth No. A-11**
Norwich, New York

For the treatment of urinary tract infections, Eaton Laboratories presents its new chemotherapeutic agent, Furadantin.® This unique nitrofuran is tailored specifically for the treatment of pyelonephritis, pyelitis and cystitis. It is intended for oral administration in those infections that have failed to respond to other medications, especially when caused by Proteus species.

Eisele & Company **Booth No. F-4**
Nashville, Tennessee

Eisele & Company will display their precision line of hypodermic syringes, hypodermic needles and clinical thermometers. This line will be offered for sale direct to the doctors at this Convention. There will be no middle men.

Electro-Medical Equipment **Booth No. F-7**
Detroit, Michigan

Gerald F. McNamara, distributor, is exhibiting the "Medcolator," a muscle stimulating machine with many applications in the physical medicine field. The unit is manufactured by the Medco Products Company of Tulsa, Oklahoma.

Encyclopedia Americana **Booth No. D-8**
Chicago, Illinois

All members of the Michigan State Medical Society are cordially invited to Booth D-8 where we will have on display, the 1953 edition of the ENCYCLOPEDIA AMERICANA and the Fortieth Anniversary Edition of the BOOK OF KNOWLEDGE.

Farnsworth Laboratories, Inc. **Booth No. F-15**
Chicago, Illinois

Fellows Medical Mfg. Company, Inc. **Booth No. E-12**
New York, New York

FELO'RAL CAPSULES—The first non-barbiturate antispasmodic sedative in soft gelatin capsules—will be featured. FELO'RAL CAPSULES (pink and white) contain Chloral Hydrate plus a fixed ratio of the naturally occurring Belladonna Alkaloids.
FELLOWS CHLORAL HYDRATE CAPSULES—A safe and effective sedative and hypnotic—will also be shown: 3¾ grain Capsules (blue and white) for daytime sedation, 7½ grain Capsules (all blue) for restful sleep. Chloral Hydrate produces a normal type of sleep without depressant aftereffects. FELLOWS representatives will be pleased to welcome you at their booth to discuss the latest developments of their Research Laboratories.
FELLOWS—The originators of Chloral Hydrate in Soft Gelatin Capsules.

Ferguson Manufacturing Company **Booth No. F-14**
Grand Rapids, Michigan

The new COLOSTOMI-PANTI for Colostomy and Ileostomy patients is the newest addition to the other DRICO Panties for children and adults with a weak bladder or bowel made by the Ferguson Manufacturing Company of Grand Rapids. Other Drico Panties consist of the Beddi-Panti for bedridden patients, Pull-on-Panti for night bed-wetters and the Ambi-Panti for extreme daytime problems connected with the bladder or bowel or menstruation problems. All Drico Panties release the mental strain patients have and allows them a new freedom from worry and they can live a normal, healthy life again because they can travel to Timbuctu without any fear of embarrassing accidents.

H. G. Fischer & Company **Booth No. B-16**
Franklin Park, Illinois

In Booth B-16, H. G. Fischer & Co. will display modern, low priced, efficient x-ray and physical therapy equipment, including FCC type approved diathermy machines. Your visit welcomed and appreciated. Interesting demonstrations gladly given—no obligation.

C. B. Fleet Company, Inc. **Booth No. B-6**
Lynchburg, Virginia

C. B. Fleet Co., Inc., cordially invites you to visit Booth No. B-6. Increasingly, during the past fifty years, to the medical profession, sodium phosphate has come to mean Phospho-Soda (Fleet), the pure, stable, aqueous solution of the two U.S.P. sodium phosphates.

Flint, Eaton & Company **Booth No. F-13**
Decatur, Illinois

The Flint, Eaton exhibit will feature Ferrolip, a new organic complex of iron. Ferrolip does not precipitate protein and thus does not cause gastrointestinal upset. Ferrolip is better absorbed as it is soluble throughout the gastrointestinal tract. The Flint, Eaton representative has an interesting demonstration to show you. Literature and samples are available.

Freeman Mfg. Company **Booth No. F-2**
Sturgis, Michigan

Makers of Orthopedic Supports

For more than sixty years Freeman has been engaged in making surgical supports and elastic hose. During that time we have worked closely with members of the medical profession. Their assistance has proved invaluable in enabling us to maintain the highest standards of quality and design.

We particularly invite your inspection of our complete line of orthopedic supports being exhibited at the show.

Geigy Pharmaceuticals **Booth No. F-8**
New York, New York

The Geigy Exhibit will feature BUTAZOLIDIN, brand of phenylbutazone, the totally new, orally effective compound with an exceptionally broad field of usefulness in arthritis and allied disorders. Also on display will be Council Accepted TROMEXAN, a safer, oral anticoagulant; EURAX Cream, a prompt-acting, antipruritic and scabicide; and PANPARNIT, indicated for symptomatic relief for Parkinson's Disease.

General Electric Company **Booth No. A-20**
Milwaukee, Wisconsin

X-Ray Department, General Electric Company, manufacturers of complete X-Ray equipment from portable diagnostic to 2,000,000-volt therapy apparatus — electrocardiograph — diathermy—X-Ray accessories and supplies. Whatever your needs, you can put your confidence in General Electric.

Gerber Products Company **Booth No. C-8**
Fremont, Michigan

Gerber's Concentrated Meat Base Formula is NEW. It is prepared to replace milk in the allergic infant's diet. It will help assure a well-fed and happy baby. Your Gerber detailman looks forward to showing you this important infant food. He also invites you to examine their COMPLETE line of baby foods. Up-to-date baby care booklets are available for your office . . . Complimentary of course.

Hanovia Chemical & Mfg. Company **Booth No. C-3**
Newark, New Jersey

See Hanovia's new diathermy for simplified controls and heavy duty performance, ultraviolet lamps for orificial and general body irradiation, Sollux Infrared Lamps, black light for diagnostic purposes and Safe-T-Aire Lamps for the destruction of air-borne bacteria. Courteous representatives will welcome your visit.

Harrower Laboratory, Inc. **Booth No. F-17**
Jersey City, New Jersey

When Harrower investigators isolated the active laxative principle of prunes they established an entirely new concept in the management of functional constipation. This principle is incorporated in two Harrower products—Prulose Complex and Isocrin. Used alone or in conjunction with one another, they cover every conceivable laxative requirement, without side effects, and with complete flexibility of individual dosage.

J. F. Hartz Company **Booth No. C-9**
Ferndale, Michigan

The J. F. Hartz Company will exhibit not only its full line of Laboratory Controlled Pharmaceuticals, but will feature the Radar Type Microtherm, and the latest in diagnostic instruments and equipment.

H. J. Heinz Company **Booth No. B-2**
Pittsburgh, Pa.

WHAT'S NEW AT THE HEINZ EXHIBIT?

1. Strained Orange Juice, Strained Cream of Tuna, Pre-Cooked Rice Cereal, and Strained Banana Custard Pudding.
2. New spill-proof plastic tumbler for weaning.
3. For office use:
   "Baby Gift Folders"
   "Nutritional Data"
   "Nutritional Observatory"
4. Literature for your patients:
   "Recipe Magic Using Heinz Strained and Junior Foods"
   "Facts About Foods"

Hoffmann-La Roche, Inc. **Booth No. E-17**
Nutley, New Jersey

DO YOU KNOW IN HOW MANY WAYS GANTRISIN CAN BE USEFUL IN YOUR PRACTICE? The Roche display will interest you because it highlights practical prescription uses for GANTRISIN—the more soluble, single sulfonamide with a wider antibacterial spectrum. You can prescribe GANTRISIN orally in tablets, syrup or pediatric suspension; for parenteral administration GANTRISIN is in ready-to-use ampuls; for local use, the ophthalmic solution, ophthalmic ointment, ear solution and nasal solution provide well-tolerated antibacterial therapy; and when you want to combine GANTRISIN with penicillin for oral administration, you can prescribe Gantricillin tablets.

Holland-Rantos Company, Inc. **Booth No. A-12**
New York, New York

Contraceptive Jelly/or Cream PLUS Diaphragm—or jelly alone? Physicians interested in medical contraception are invited to discuss this timely question with H-R convention representatives. Koromex Diaphragm plus Koromex Jelly/or Cream, means *consistently effective protection.*

G. A. Ingram Company **Booths Nos. D-4, D-5, D-6**
Detroit, Michigan

On display at our booth will be the newest types of physical-medicine equipment, such as the Ultrasonic unit and the Vaso-Pneumatic unit. The Vaso-Pneumatic machine is a new approach to the treatment of peripheral vascular diseases. We will also have a complete display of the newer wood and metal examining tables, as well as numerous diagnostic instruments. As usual, we will have a representative display of Stille and domestic surgical instruments.

C. B. Kendall Company **Booth No. C-14**
Indianapolis, Indiana

A number of ethical specialty products of interest to internists, cardiologists, and general practitioners will be displayed at our booth. Representatives, prepared to explain the features of our products, will welcome your visit, whether to chat, rest awhile or to renew old acquaintances.

Kremers-Urban Company **Booth No. F-18**
Milwaukee, Wisconsin

K-U representatives invite you to stop by and become acquainted with MILKINOL, the new instant-mixing, self emulsifying mineral oil. The new mineral oil laxative, as pleasant to take as the favorite beverage. KUSED will also be featured. This new K-U sedative provides balanced sedation all along the line.

A. Kuhlman & Company **Booth No. A-17**
Detroit, Michigan

Lea & Febiger **Booth No. A-8**
Philadelphia, Pa.

The Lea & Febiger exhibit will feature these new books and new editions: Hollander—Comroe's Arthritis and Allied Conditions; Joslin—Treatment of Diabetes Mellitus; Goldberger—Unipolar Lead Electrocardiography and Vectocardiography; Burch, Abildskov and Cronvic—Spatial Vectorcardiography; Bellet—Clinical Disorders of the Heart Beat; Pratt—Surgical Management of Vascular Diseases; Partipilo—Surgical Technique and Principles of Operative Surgery; Herbut—Gynecological and Obstetrical Pathology; Portis—Diseases of the Digestive System; Lichtman—Diseases of the Liver, Gallbladder and Bile Ducts; Cozen—Office Orthopedics; and Delario—Roentgen, Radium and Radioisotope Therapy.

Lederle Laboratories **Booth No. A-14**
New York, New York

You are cordially invited to visit our exhibit where you will find representatives prepared to give you the latest information on LEDERLE products.

Liebel-Flarsheim Company **Booth No. D-14**
Cincinnati, Ohio

THE LIEBEL-FLARSHEIM COMPANY, Cincinnati, Ohio, manufacturers of electromedical equipment for over thirty-five years, cordially invites you to visit Booth Number D-14 in which their latest short-wave diathermy and Bovie electrosurgical apparatus will be available for examination and demonstration. Capable representatives will be on hand at all times, and we hope you will stop by so that we may become acquainted.

Eli Lilly & Company **Booth No. E-1**
Indianapolis, Indiana

You are cordially invited to visit the Lilly exhibit located in space number E-1. New antibiotics, cardiac drugs, and antihistamines are featured in the display. Lilly salesmen will welcome your questions about these and other recent therapeutic developments.

J. B. Lippincott Company **Booth No. B-17**
Philadelphia, Pa.

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

P. Lorillard Company **Booths Nos. F-5, F-6**
New York, New York

P. Lorillard Company, manufacturers of OLD GOLD and EMBASSY Cigarettes as well as BRIGGS Pipe Mixture and other famous tobacco products, will exhibit and demonstrate their new KENT Cigarettes with the exclusive Micronite Filter, which takes out up to 7 times more nicotine and tars than other filter cigarettes.

M & R Laboratories, Inc. **Booth No. B-12**
Columbus, Ohio

Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference Reports. Also available are current reprints of pediatric nutritional interest.

Maico Company, Inc. **Booth No. E-3**
Grand Rapids, Michigan

MAICO products (Medical Acoustic Instrument Co.) are well known to the medical profession. Their audiometers and hearing aids are unexcelled for excellence in precision and reliability in giving service to their users.

Ninety per cent of all precision hearing test equipment used in the United States by doctors, hospitals, schools, clinics, etc., are supplied by the Maico Company, Inc.

S. E. Massengill Company **Booth No. B-5**
Bristol, Tennessee

You are invited to visit The S. E. Massengill Company booth. The new Adrenosem, indicated for the control of bleeding, is featured and representatives will be glad to discuss with you latest developments on this medication. Other recent developments of the Massengill Laboratories are on display and you are welcome to register for samples which will be mailed directly to your office.

Mead Johnson & Company **Booth Nos. E-7, E-8**
Evansville, Indiana

MEAD JOHNSON & COMPANY, Evansville, Indiana, Booths No. E-7 and E-8, will feature the change in the formulation of Dextri-Maltose, the dried carbohydrate, designed specially for use in infant formulas. In addition to Natalins, small capsules containing vitamins and minerals, designed particularly for use in pregnancy and lactation; the Vi-Sols and four Pablum Cereals will be on display.

Representatives in attendance will be glad to furnish information regarding the above products.

Medical Arts Surgical Supply Company **Booth Nos.**
Grand Rapids, Michigan **C-4, C-5**

Meet the Medical Arts Boys in Booths C-4 and C-5. They will be pleased to show you many new things of diagnostic, treatment and ease of practice value. Stop in; they will welcome you.

Medical Protective Company **Booth No. D-9**
Fort Wayne, Indiana

Specialized Service in Professional Protection Exclusively—distinctive of The Medical Protective Company—assures a "know-how" in Defense and proven Protection against loss that have most successfully met attacks arising out of the Doctor-Patient relationship for more than half a century. For authoritative information consult our representatives at Booth D-9.

Merck & Company, Inc. **Booth No. B-10**
Rahway, New Jersey

MERCK & CO., Inc., is featuring HYDROCORTONE, CORTONE, MEPHYTON, NALLINE and other medicinal preparations.

HYDROCORTONE and CORTONE are supplied in forms convenient for use in the wide range of their clinical applications: HYDROCORTONE in tablet form (20 mg.); as saline suspension for intra-articular injection (25 mgm. per cc.); as topical ointment for dermatological use (2.5 per cent); and as dental ointment (2.5 per cent).

CORTONE is supplied in tablet form for oral administration (5 and 25 mg.); as saline suspension for parenteral use (25 and 50 mgm. per cc.); as ophthalmic ointment (1.5 per cent); and in ophthalmic suspensions (0.5 per cent and 2.5 per cent).

MEPHYTON is an anitidote to anticoagulant-induced hypoprothrombinemia. It promptly reverses the pro-

thrombin deficiency induced by coumarin-like compounds.
NALLINE is the first dependable narcotic antagonist. It promptly reverses the respiratory depression that may be produced by morphine or its derivatives as well as meperidene and methadone.

Wm. S. Merrell Company **Booth No. E-9**
Cincinnati, Ohio

For prompt, effective and COMFORTABLE relaxation of gastrointestinal smooth muscle spasm, Merrell presents BENTYL Hydrochloride.
BENTYL is a high milligram potency non-narcotic antispasmodic with twofold musculotropic and neurotropic action. Bentyl is therapeutically effective in functional gastrointestinal disorders without atropine-like side actions.
BENTYL is particularly suited for prolonged administration without habituation or increased tolerance.

Michigan Medical Service **Booth No. B-1**
Detroit, Michigan

The Blue Shield exhibit exemplifies the prepayment plan sponsored by the doctors in Michigan and what that plan means to the people of the State. The family scene is typical of a family who have been relieved of the worry of catastrophic medical bills.
The photograph of the doctor and the child which makes up the Blue Shield portion of the exhibit, is symbolic of the co-operation of the doctors of Michigan. Through that co-operation Blue Shield in Michigan has led the nation in meeting the needs of the public.

Middleton's Incorporated **Booth No. E-5**
Grand Rapids, Michigan

Middleton's, Inc., bring to the busy doctor the newest in imported surgical instruments and manometers. Also those special requirements for the busy doctor to have handy in office supplies.
Stop in, see those new World Famous "Jena Glass Syringes with Luer tip" with special blue ring plunger. Complete selection of Serratex Non-slip Scissors with the ideal "positive-cut." See those "Pedia-Treat" tongue blades the kiddoa say-Ah.
Everything for the Discriminating Physician.

Miller Surgical Company **Booth No. F-1**
Chicago, Illinois

MILLER SURGICAL COMPANY will show the Miller Electro-scalpel. This unit cuts, dessicates, fulgerates, coagulates and is used for most delicate work up to light major surgery. It is a complete office unit, portable, weighing 19 pounds with cords, handles, foot switch, and accessories such as Insulated Snares, Smoke Ejector, et cetera. Also a complete line of Diagnostic Equipment consisting of Illuminated Otoscopes, Ophthalmoscopes, Eyespuds with Magnet, Transillumination Lamps, Headlights, Vaginal Speculum, Gorsch Operating Scopes and Stainless Steel Proctoscopes all sizes with magnification, Suction Tubes and Grasping Forceps.

C. V. Mosby Company **Booth No. A-3**
St. Louis, Missouri

New and interesting titles will be on display at the C. V. Mosby Company Booth No. A-3, where you are invited to visit and browse at your leisure. Among some of the more recent releases are Horsley-Bigger "Operative Surgery," Crossen "Diseases of Women," Weinstein-Foldes "Glaucoma," Ackerman "Surgical Pathology," Dock-Mandelbaum "Ballistocardiography," Jensen "Modern Concepts in Medicine," and many others.

National Drug Company **Booth No. A-26**
Philadelphia, Pennsylvania

The National Drug Company cordially invites you to visit their booth. Dimethylane, AVC Improved and Resion will be displayed. Dimethylane is a new, versatile compound for controlling symptoms of dysmenorrhea, the menopause, and associated tension states. AVC Improved is effective against an extremely wide range of vaginal tract infections. Resion offers a more rapid and more complete control of diarrhea in infants and adults; also for controlling nausea of pregnancy, food poisoning and enteric infections.

Nepera Chemical Company, Inc. **Booth No. F-10**
Yonkers, New York

The Nepera exhibit features its new product Biomydrin Nasal Solution in a plastic atomizer package which is effective against sinusitis and allergic and infectious rhinitis. Thonzonium Bromide, a new wetting agent with wide spectrum antibacterial and mucolytic properties, product of Nepera research, is included among other ingredients in the formula.
Also included will be Mandelamine, the Urinary antiseptic, and Neohetramine, a highly effective antihistamine.

Wm. R. Niedelson Company **Booth No. C-1**
Detroit, Michigan

Models of the Jones Metabolism unit, the "AIR-BASAL," the newest advance in BMR testers requiring NO oxygen tank will be shown.
The new model improved CARDIOTRON direct-writing Cardiograph with rectilinear response will be demonstrated.
PROFEXRAY equipment and accessories.

Noble-Blackmer, Inc. **Booth Nos. C-11, C-12**
Jackson, Michigan

Your friendly representatives from Jackson will again be in attendance at your Convention to show you the latest in Pelton and Castle sterilizing and office lighting equipment, office examining room furniture, surgical instruments and Birtcher shortwave electrosurgical equipment.

Ortho Pharamaceutical Corporation **Booth No. B-4**
Raritan, New Jersey

ORTHO cordially invites you to visit their exhibit at booth B-4. The Ortho display will feature PRECEPTIN® vaginal gel, their new product for conception control designed for use without a vaginal diaphragm. Preceptin vaginal gel has achieved an outstanding record of clinical effectiveness and has been widely acclaimed by the medical profession. Your inquiries on Preceptin vaginal gel are invited.

Parke, Davis & Company **Booth Nos. A-1, A-2**
Detroit, Michigan

A cordial welcome awaits you at the Parke-Davis booth. Members of our Medical Service Staff will be on hand to greet you and discuss any of our products in which you may be particularly interested.

Pelton & Crane Company **Booth No. B-13**
Detroit, Michigan

Pet Milk Company **Booth No. A-25**
St. Louis, Missouri

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

Chas. Pfizer & Company, Inc. **Booth No. E-11**
Brooklyn, New York

Terramycin, newest of the broad-spectrum antibiotic forms a dramatic central feature of the display of Chas. Pfizer & Co., Inc., Brooklyn, New York. The newest dosage forms of Terramycin are exhibited and indications for use are described.

Procter & Gamble Company **Booth No. D-13**
Cincinnati, Ohio

The Procter & Gamble Company offers a series of time-saving leaflets for doctors: "Instructions—Routine Care of Acne"; "Instructions—Bathing a Patient in Bed"; "Instructions—Bathing Baby"; "Hygiene of Pregnancy"; "Home Care of the Bedfast Patient" and "Instructions—Sickroom Precautions." There also will be samples of other material prepared for physicians.
Mrs. Christyne Schwab, in charge.

Professional Management **Booth No. D-3**
Battle Creek, Michigan

PM

PROFESSIONAL MANAGEMENT—with 20 years of specializing in *The Business Side of Medicine*—invites you to stop at Booth No. D-3.
Offices in Battle Creek, Saginaw, Grand Rapids and Detroit.

The Quarry, Incorporated **Booth No. F-9**
Ann Arbor, Michigan

Randolph Surgical Supply Company **Booth Nos.**
Detroit, Michigan **B-8, B-9**

Riker Laboratories, Inc. **Booth No. F-19**
Los Angeles, California

Riker Laboratories, Inc., presents RAUWILOID, an alkaloidal extract of the root of Rauwolfia serpentina. A new and distinctly different hypotensive agent, outstanding for its ability to control associated symptoms and freedom from side actions. The representatives at our booth will be glad to give you complete information on this product.

A. H. Robins Company, Inc. **Booth No. B-19**
Richmond, Virginia

Physicians attending the Michigan State Medical Society are extended a cordial invitation to visit the exhibit of the A. H. Robins Company, which is this year celebrating its seventy-fifth year of service to the medical profession.
Experienced representatives will be in attendance to welcome you and answer inquiries relative to Robins' prescription specialties.

J. B. Roerig & Company **Booth No. F-16**
Chicago, Illinois

Members of the Michigan State Medical Society are cordially invited to visit the booth of J. B. Roerig and Company. Professional Service Representatives will be on hand to welcome all interested visitors.

Rystan Company, Inc. **Booth No. C-6**
Mount Vernon, New York

In addition to Council-accepted Chloresium Ointment and Solution for resistant wounds, burns and ulcerations, Rystan features Prophyllin, a new dermatologic. Prophyllin combines sodium propionate and water-soluble chlorophyll to provide a soothing, odorless, mildly bacteriostatic and fungistatic wet dressing for the treatment of a wide variety of dermatoses. Also available as ointment.

Sandoz Pharmaceuticals **Booth No. A-9**
New York, New York

We plan to feature *new* information on certain established products and complete data on Fiorinal—the newest member in our family of ethical specialties in Cephalalgia therapy.

CAFERGOT: the first effective oral therapy for migraine and related vascular headaches—clinically proven in thousands of reported cases since 1949.

BELLERGAL: valuable as an autonomic inhibitor in a variety of functional ills—the volume of favorable clinical reports is constantly increasing.

FIORINAL: a new approach to therapy of tension headache and other head pain due to sinusitis and myalgia.

A variety of informational brochures will be available and our representatives will be happy to provide full information concerning the above and other ethical pharmaceutical products of the Sandoz organization.

W. B. Saunders Company **Booth No. A-5**
Philadelphia, Pennsylvania

Mr. Ross Patterson will be on hand with the complete Saunders line.
A few new books of special interest will be GROSS—SURGERY OF INFANCY AND CHILDHOOD; PARSONS AND ULFELDER—AN ATLAS OF PELVIC OPERATIONS; NEW A.M.A. FUNDAMENTALS OF ANESTHESIA.
Your interest will be appreciated.

Schering Corporation **Booth No. B-18**
Bloomfield, New Jersey

SCHERING CORPORATION, Bloomfield, New Jersey (Booth No. B-18). Members of the Michigan State Medical Society and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured.
Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

Julius Schmid, Inc. **Booth No. A-24**
New York, New York

Julius Schmid, Inc., will display here RAMSES Gynecological Products. Not only do RAMSES Flexible Cushioned Diaphragm, RAMSES Vaginal Jelly as well as all other RAMSES Gynecological Products meet or exceed A.M.A. Council Acceptance but after more than three decades of acceptance by the medical profession, those best qualified to judge are showing greater preference than ever before for RAMSES Gynecological Products.

Sealtest Dairy Products **Booth No. A-22**
Grand Rapids, Michigan

Sealtest
DAIRY PRODUCTS

For that refreshing pick-up between meetings, look for the red and white symbol of quality and enjoy a complimentary bottle of Sealtest Milk — known to all doctors of medicine.

Get the best—get Sealtest milk and ice cream.

G. D. Searle & Company **Booth No. A-27**
Chicago, Illinois

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.
Featured will be Vallestril, the new synthetic estrogen for menopausal symptoms; Pro-Banthine, the true anticholinergic drug for the treatment of peptic ulcers; and Dramamine, for the prevention and active treatment of motion sickness.

Sharp & Dohme, Inc. **Booth No. D-18**
Philadelphia, Pennsylvania

Research data relative to oral penicillin therapy is featured at the Sharp & Dohme technical display. The exhibit endeavors to justify reliance on oral penicillin for the therapy of the majority of penicillin treatable infections, excluding fulminating diseases requiring hospitalization. A résumé of pharmacological attributes of certain nasal decongestants completes the exhibit. Expertly trained personnel will be present to discuss these observations.

Smith, Kline & French Laboratories **Booth No. E-4**
Philadelphia, Pennsylvania

The S.K.F. Booth will feature "Spansules"—the revolutionary new oral dosage form. Just one "Spansule," taken on arising, provides a uniform supply of medication throughout the day. Thus, "Spansules" offer you three advantages: (1) smooth, uniform action, (2) prolonged therapeutic effect, and (3) convenient once-a-day dosage.

E. R. Squibb & Sons **Booth No. A-7**
New York, New York

New Squibb products, and new brochures of useful interest to you on products already introduced, will be featured at Booth No. A-7.
As in former years, your Squibb representative again cordially invites you to visit the Squibb booth.

The Stuart Company **Booth No. E-6**
Chicago, Illinois

You are cordially invited to visit our exhibit where you will find our representatives prepared to give you the latest information on Stuart products.

Testagar & Company, Inc. **Booth No. C-2**
Detroit, Michigan

The professional service representatives of Testagar and Company, Inc., will present the newest development in the antacid anti-spasmodic combination therapy, SPEROTABS No. 2. This represents a combination of two of the new dense magnesium salts plus two more antacids which combine not only to neutralize access gastric acidity without causing alkalosis, but also to form a protective coating over an ulcer crater. In clinical tests so far SPEROTABS have proven to be considerably more than just "another antacid." We will also introduce a new very effective skeletal muscle relaxant MYOMEPHETAINE.
Our complete line of injectable solutions will also be shown.

Travenol Laboratories, Inc. **Booth No. A-4**
Morton Grove, Illinois

The Upjohn Company **Booth Nos. D-11, D-12**
Kalamazoo, Michigan

The importance of Cortisone is expanding as clinicians discover new applications. The Upjohn Company is justly proud of its part in the development of Cortisone and in its discovery of new production methods. It is our aim to make Cortisone available to ever increasing numbers. Competent representatives welcome your inquiries and discussion.

U. S. Vitamin Corporation **Booth No. E-16**
New York, New York

Exhibit features original, complete lipotropic therapy . . . METHISCHOL . . . the combination of five proven lipotropic agents: B_{12}, choline, methionine, inositol and liver extract. Therapeutically effective in the treatment of hypercholesterolemia as associated with atherosclerosis, coronary disease, obesity, diabetes and various forms of liver disease, including liver cirrhosis and toxic hepatitis.

Vaisey-Bristol Shoe Company, Inc. **Booth No. E-13**
Monett, Missouri

Representatives will explain the rationale of the round heel shoe and the importance of the round heel of the foot as it affects foot function.
Jumping Jacks are not "corrective" shoes but may be used as a diagnostic aid because the foot print which appears on the sole presents a case history of the child's foot function.

Varick Pharmacal Company **Booth No. E-14**
New York, New York

Varick Pharmacal Co., Inc.—E. Fougera & Co., Inc., cordially invite physicians to discuss with professional service representatives new preparations of importance to their every day practice. Descriptive literature and samples of all products will be available.

Westinghouse X-Ray Company **Booth No. C-16**
Baltimore, Maryland

The Westinghouse exhibit will consist of a Westinghouse background with our own drapes, an accessory cabinet displaying accessory items pertaining to x-ray, and a four-bank illuminator with translites showing various pieces of x-ray equipment. In the booth will be several chairs for the doctors to relax.

Westwood Pharmaceuticals **Booth No. E-2**
Buffalo, New York

Westwood introduces the first really effective skin protective—PRO-DERNA silicone cream. It protects sensitive skin against such common irritants as soap, water, wool, saliva, urine, rectal and vaginal discharges and many industrial irritants. Suggested for housewife's eczema, diaper rash, chafing, industrial dermatitis, rectal and vulvar itch and other externally caused skin irritations.

White Laboratories **Booth No. D-7**
Kenilworth, New Jersey

White's "Phonoscope," Booth No. D-7, enables you to hear some of the heart sounds commonly encountered in clinical medicine and to see graphically displayed the associated electrocardiograms, carotid artery pulsations and apical stethograms. GITALIGIN (amorphous gitalin) which has been described as a ". . . digitalis preparation of choice" will be on display.

Winthrop-Stearns, Inc. **Booth No. E-19**
New York, New York

WINTHROP-STEARNS, INC., New York, invite you to visit booth E-19, where the following products will be featured—ALEVAIRE, nontoxic inhalant which thins sticky pulmonary secretions in bronchitis, bronchiectasis, and neo-natal asphyxia; TELEPAQUE, the new, highly effective and well tolerated oral cholecystopaque medium. Gives denser, clear cut pictures of the gallbladder and, in a substantial number of cases, also permits visualization of the biliary ducts.

Woodward Medical Personnel Bureau **Booth No. A-6**
Chicago, Illinois

To those doctors seeking to relocate, or to physicians who wish to reorganize or augment their present staff, Ann Woodward offers the facilities of the Woodward Medical Personnel Bureau. The details of excellent opportunities for above-average income, with good security and fine future potential may be investigated. You may also review the records of some exceptionally well-qualified younger doctors just finishing their formal training as well as diplomates of the specialties qualified to head departments. The complete files for these purposes may be found at Booth A-6 where Mrs. Woodward will be available to greet and assist you.

Wyeth, Incorporated **Booth No. A-21**
Philadelphia, Pennsylvania

Wyeth will feature PLAVOLEX^{R}, 6% dextran solution for use as a plasma volume expander. Among the advantages of dextran is its freedom from the danger of transmitting virus hepatitis. See also various dosage forms and combinations of BICILLIN^{R}, the new form of penicillin— strikingly low in side effects— and THIOMEIN^{R}, a smooth acting, effective mercurial diuretic, suitable for subcutaneous administration.

Zemmer Company **Booth No. F-12**
Pittsburgh, Pennsylvania

Our exhibit this year will be under the supervision of Lou Harley. Among the items on display will be Tablets Hysobel, a formula intended for the treatment of obesity.

Zimmer Manufacturing Company **Booth No. D-19**
Warsaw, Indiana

Mr. C. A. Fisher, your ZIMMER distributor, extends a most cordial invitation to the members of the Michigan State Medical Society to visit our display at Booth D-19.

Our exhibit this year will feature Femoral Prosthetic Heads, Intramedullary Pins and Instruments, Osteotomes, Gouges, Retractors, Woodruff Cut Pilot Point Bone Screws, Brown Electro-Dermatome, Pugh Nail and the new Varo-Met Pneumatic Tourniquet.

To our business friends in the Exhibit, the Michigan State Medical Society expresses sincere thanks for their splendid co-operation and very tangible contribution to the great success of the 1953 Michigan State Medical Society Annual Session.

ST. LUKE'S HOSPITAL CLINICO-PATHOLOGIC CONFERENCE

(Continued from Page 745)

2. Amyloidosis of bone marrow, lymph nodes, and right and left adrenals.

3. Bronchopneumonia of right and left lungs, with abscess formation.

4. Anthracosilicosis of right and left lungs and mediastinal and parabronchial lymph nodes.

DR. J. C. SMITH: Autopsy examination revealed extensive infiltration of bone marrow with plasma cells and widespread replacement with amyloid. The marrow of the vertebral column was soft and compression fractures were present (Fig. 1). Histologic examination revealed rows of plasma cells embedded in the clear, pink amyloid deposits (Fig. 2). The cause of death is attributed to extensive bronchopneumonia with abscess formation.

Breitenbucher and Hertzog[1] reported on ninety-five cases of multiple myeloma with autopsy examination of seventy-five. There were seventy-one male patients and twenty-four female. Seventy-four of the patients were over fifty and only eleven were over seventy. Tabulation of presenting signs and symptoms revealed the most frequent to be pain in the back or thorax, loss of weight, pathologic fracture, and a palpable mass on a superficial bone. X-ray examinations revealed the order of frequency of involved bones to be: spine 80, ribs 74, skull 55, pelvis 39, and sternum 28. The bones of the appendages were less frequently affected. Extra-osseous involvement was uncommon and affected liver, spleen, lymph nodes, and kidneys. The same laboratory determinations were not uniformly performed. However, Bence-Jones proteinuria occurred in twenty-three of fifty-four (42 per cent), hyperglobulinemia in thirty of fifty (60 per cent), hypercalcemia in twenty-two of thirty-seven (60 per cent), elevated serum phosphorus in eleven of twenty-four (49 per cent), and elevated serum alkaline phosphatase in four of seventeen (25 per cent). According to Lichtenstein and Jaffe[2], normocytic anemia occurs in approximately 70 per cent. Most patients lived less than three years although several lived considerably longer. Complications include renal failure, pathologic fracture, bronchopneumonia, and amyloidosis. Lichenstein and Jaffe[2] found 463 case reports of multiple myeloma in the literature and of these, amyloidosis was present in forty. If there are no further comments, the meeting is adjourned.

References

1. Breitenbucher, R. B., and Hertzog, A. J.: Multiple myeloma. A review of ninety-five proven cases with seventy-five autopsies. Minnesota Med., 32:986, 1949.

2. Lichtenstein, L., and Jaffe, H. L.: Multiple myeloma. A survey based on thirty-five cases, eighteen of which came to autopsy. Arch. Path., 44:207, 1947.

Two-thirds of the postoperative cancer deaths occur in patients fifty-five years of age or more.

* * *

A chest x-ray and an electrocardiogram are important preoperative studies on cancer patients.

* * *

Many patients with cancer, by the time they reach the surgeon, exhibit some evidence of nutritional deficiency.

Annual Reports

ANNUAL REPORT OF PERMANENT CONFERENCE COMMITTEE (with Michigan Hospital Association and Michigan League for Nursing) 1952-1953

This Committee met in Lansing on April 22, 1953.

The problems for consideration by this group have been less numerous this year than during previous years. The following topics were taken under consideration:

1. A formula concerning the ratio between special and general duty nurses' salaries: Due to disparity in the salary sources no solution has been reached.
2. Education of male nurses: While many nursing schools will accept men as students, there are very few who apply. This is probably due to the wide labor market now available to anyone wishing work in manufacturing production at much higher rates of pay.
3. A survey of nursing needs and sources: This survey, which will be financed by the Cunningham Drug Company Foundation of Detroit, and sponsored by all nursing agencies, will be performed by Miss Abdellah of the United States Public Health Service. The findings of this survey will be cleared through this Committee before being published.
4. A two-year Junior College course for nurses: To date this is strictly a pilot study program to be carried out at the Ford Junior College in Dearborn. As proposed, the course will consist of four semesters of which six hours per week will be practical, the remainder to be academic. It may take several years before the results are known.

Respectfully submitted,
JOSEPH A. WITTER, M.D., *Chairman*
C. G. CLIPPERT, M.D.
J. E. LIVESAY, M.D.
E. G. MERRITT, M.D.
J. D. MILLER, M.D.
G. J. MORIARTY, M.D.
E. M. VARDON, M.D.

ANNUAL REPORT OF COMMITTEE TO REVISE THE MODEL CONSTITUTION AND BY-LAWS FOR COUNTY SOCIETIES—1952-53

A meeting of the Committee to Revise the Model Constitution and By-Laws for County Societies was held in Detroit, Michigan, on May 27, 1953. A revision was submitted, and the Committee decided to make a further study of same.

Respectfully submitted,
J. H. SCHLEMER, M.D., *Chairman*
F. M. DOYLE, M.D.
C. W. OAKES, M.D.
P. E. SUTTON, M.D.

ANNUAL REPORT OF THE MICHIGAN STATE MEDICAL ASSISTANT'S ADVISORY COMMITTEE —1952-53

On January 31, 1953, the Medical Advisory Board met with the Executive Committee of the Michigan State Medical Assistant's Society. Various queries made by the Executive Committee in the interest of good co-operation between the Assistants and the State Medical Society were discussed. Representatives of the group met with the Women's Auxiliary on March 11, in Detroit. Plans were also made for the annual meeting in connection with the State Meeting in September.

During the year it was interesting to note that a new chapter, The Genesee County Medical Assistants Society, was organized in Flint on April 12, 1953. Thirty-four girls were present at this meeting.

The Medical Assistants Society is growing rapidly and functioning admirably. It is recognized by all doctors that it is an important factor in the relationship between the doctor and his patients.

Respectfully submitted,
H. H. HEUSER, M.D., *Chairman*
H. M. BISHOP, M.D.
R. W. EMERICK, M.D.
E. A. OSIUS, M.D.
R. W. POMEROY, M.D.
E. C. SWANSON, M.D.
OTTO VAN DER VELDE, M.D.
RALPH W. SHOOK, M.D., *Advisor*

ANNUAL REPORT OF THE SPECIAL COMMITTEE TO MEET WITH THE MICHIGAN DEPARTMENT OF SOCIAL WELFARE— 1952-53

As in previous years, your Committee continued as an integral part of a permanent Advisory Committee appointed by the State Welfare Commission. One change in membership occurred when Frank L. Doran, M.D., replaced President R. J. Hubbell, M.D.

Meetings were held in December, 1952, and February, 1953, at which times the legal provisions affecting physicians who desire to assist in placing infants for adoption was thoroughly reviewed and discussed and a draft on an article was approved for publication in THE JOURNAL of MSMS. Also, new and more restrictive definition on mental incapacity as a basis for eligibility for Aid to Dependent Children was formulated and accepted by the Welfare Commission.

Many other problems were discussed, such as, legal protection of physician in releasing information to County Bureau of Social Aid, special diets to recipients of Categorical Aid, the use of the local medical consultant and a review of how local Bureaus are functioning.

The Social Welfare Commission has again thanked us for our co-operation and desires a continuation of the Committee.

Respectfully submitted,
G. W. SLAGLE, M.D., *Chairman*
FRANK L. DORAN, M.D.
WILFRED HAUGHEY, M.D.
L. G. CHRISTIAN, M.D. *Ex-officio representing Welfare Commission.*

ANNUAL REPORT OF MATERNAL HEALTH COMMITTEE—1952-53

Meetings were held December 2, 1952, and April 16, 1953. The majority of the energy of the Committee is still expended in the work with the Michigan Maternal Mortality Survey. This is a five year survey and the case reports for years 1950 through 1952, are being reviewed by the Reviewing Committee and being studied by the Publications Committee which has in mind sending certain reports for publication within the next few months. The reports, when published, will occur in the JAMA and THE JOURNAL of the Michigan State Medical Society. The committee is hoping that these published reports will be helpful to all doctors practicing obstetrics in the State of Michigan.

The Committee continued to act as consultant and advisor to the Michigan Department of Health with respect to "Rules and Regulations for Hospitals with Maternity Departments." After about one year's experience with the rules and regulations, the Health Department reported the need for re-consideration. The entire pamphlet was therefore reviewed, and while the changes made

were not essentially changing the character of the pamphlet, it was found desirable to make a number of small corrections and alterations. Only one rule and regulation of major importance was changed, namely, the mandatory thirty-day Kahn test (thirty days before delivery). At present the rule provides that the serology examination 30 days before term is a good policy but not mandatory.

The sub-committee having to do with the parent education throughout the state is at work but as yet reports progress without being able to formulate a more detailed description of accomplishment.

One of the considerations of the Committee has to do with the future possibility of surveying the infant morbidity and mortality throughout the state similar to present survey of maternal mortality. While the Committee is in agreement that this is an excellent project, it remains to be accomplished in the future.

During the past year the committee has felt deeply the loss of three of its members—Dr. G. M. Byington by retirement, Dr. A. M. Campbell by illness, and Dr. D. M. Schuitema by death.

The Committee wishes to express appreciation for the secretarial service and attendance at its meetings of the MSMS Associate Public Relations Counsel, John B. Kantner.

Also to Fannie H. Kenyon, M.D., for her part in the review of the rules and regulations from the Michigan Department of Health.

Respectfully submitted,

P. E. Sutton, M.D., *Chairman*
C. D. Barrett, Jr., M.D.
C. M. Bell, M.D.
W. G. Birch, M.D.
A. M. Campbell, M.D.
G. B. Corneliuson, M.D.
A. L. Foley, M.D.
Francis Jones, Jr., M.D.
H. W. Longyear, M.D.
S. T. Lowe, M.D.
H. A. Ott, M.D.
H. A. Pearse, M.D.
L. C. Spademan, M.D.
D. W. Thorup, M.D.
Kathryn D. Weburg, M.D.
H. R. Williams, M.D.

ANNUAL REPORT OF CANCER CONTROL COMMITTEE—1953

The Committee held three meetings during the year: November 13, 1952; February 5, and April 30, 1953.

For the fourth successive year, the Committee sponsored and developed the Michigan Cancer Conference held at the Kellogg Center for Continuing Education, East Lansing, on October 9, 1953. The meeting was held in connection with the Annual Training School of the Michigan Division, American Cancer Society, and was co-sponsored by the Cancer Society and the Michigan Department of Health. Approximately 300 lay and professional delegates were in attendance. The following program was concluded with a luncheon, and question and answer period.

Introductory Address—Some Aspects of the Cancer Problem in Michigan
R. J. Hubbell, M.D., Kalamazoo, President
Michigan State Medical Society

Is Progress Being Made in Cancer Control?
C. Allen Payne, M.D., Grand Rapids,
Pathologist, Blodgett Memorial Hospital

Cancer Diagnostic Tests
Freddy Homburger, M.D., Boston, Mass.
Research Professor of Medicine, Tufts College Medical School

Recess

The Local Health Department's Responsibility in Cancer Control
Otto K. Engelke, M.D., Ann Arbor
Director, Washtenaw County Health Department

Cancer Control—The Price and the Payoff
Miss Margaret E. Siebert, Lansing
Michigan Federation, Business and Professional Women, Inc.

The papers given at the Conference were published in the April, 1953, issue of The Journal, MSMS.

The program of the Fifth Michigan Cancer Conference has been completed. It is scheduled to be held in cooperation with the two Michigan Divisions, American Cancer Society, at the Kellogg Center, East Lansing, October 21. This Conference, as those preceding, is being co-sponsored by the two state divisions, American Cancer Society and the Michigan Department of Health.

On request of the Michigan State Medical Society, the Committee organized a half-day cancer symposium at the Michigan Clinical Institute on March 12, 1953. Four speakers discussed various cancer problems as follows:

Diagnostic Problems in Cancer
Raymond W. Houde, M.D., New York, New York
In Charge Examining Office, Memorial Hospital

Use of Morbidity Records in Cancer Control Programs
Matthew H. Griswold, M.D., Hartford, Connecticut
Chief, Division of Cancer and Other Chronic Diseases, Connecticut State Department of Health; Lecturer in Public Health, Yale School of Public Health

The R. S. Sykes Lecture—Cancer in Childhood
Harold W. Dargeon, M.D., New York, New York
Attending Pediatrician, Memorial Hospital and St. Luke's Hospital

Diagnostic Problems in Skin Cancer
James R. Driver, M.D., Cleveland, Ohio
Association Clinical Professor of Dermatology, School of Medicine, Western Reserve University.

In October, 1952, 5,000 copies of *The Story of Cancer for High Schools* were printed and five copies were distributed to each public and parochial high school of Michigan. In many counties, the distribution was made by the local cancer unit. In other counties the manuals were sent direct to the schools. This printing was made possible by a generous contribution from the Michigan Department of Health.

Soon after these manuals were distributed, requests by schools and other groups for additional copies began to come in. The local cancer units were again circularized to determine how many additional copies were wanted in their areas, also if they would pay for such copies. The Committee had no funds for a reprinting and would have to charge for additional copies needed. The demand and the willingness to pay were such that 10,000 additional copies were printed in March, 1953. At the time of preparing this report, June 1, less than 1,700 copies of this high school manual are on hand and a second reprint order is being considered.

There has been a widespread interest in this manual from practically all states and territories as well as from several foreign countries.

During the year the Committee has been studying the programs of all cancer organizations in the state and attempting a closer co-ordination of these programs as their projects touch on statewide problems. Encouraging progress has been made in this regard.

By invitation, a Committee member assisted in a cancer seminar for high school teachers in Ottawa County during November and December, 1952.

A representative of the Committee spent two days each in Kalamazoo and Van Buren Counties speaking before high school and Parent Teacher Association meetings.

At the Michigan Clinical Institute in March, 1953, the Michigan State Medical Society presented scrolls to three committee members: To Norman F. Miller, M.D., Ad-

visor, for his unequalled record of a 100 per cent follow-up on more than 3,150 cases of gynecological cancer; to H. M. Nelson, M.D., in honor of his election as president of the American Cancer Society; and to F. L. Rector, M.D., Secretary, for his contributions to lay cancer education, especially to high school cancer education.

Members of the Committee served as Chairman and Secretary, respectively, of the Committee on Arrangements for the Testimonial Dinner to Dr. H. M. Nelson, for the honor mentioned above.

All requests for information or service the Committee could render have been complied with during the year.

The program of "Every Doctor's Office a Cancer Detection Center" has been stressed throughout the year.

The Hillsdale Plan has continued to function throughout the year. On December 30, 1952, it concluded five years of operation. A careful five-year evaluation and report on this plan is in preparation and will be available later in the year. This plan continues to enlist the interest of other local and statewide medical organizations. The State of Washington Medical Society is the latest such organization to adopt this plan.

The Secretary of the Committee has submitted his resignation effective September 30, 1953. At this time, he wishes to express to the Committee members of the past seven years and to the officers and executives of the Michigan State Medical Society, his appreciation and thanks for their support and co-operation in carrying out the duties that have been assigned to his office. He bespeaks for his successor the same cordial relationships with future Committees.

The Committee takes cognizance of Dr. Rector's resignation with regret and herewith expresses the consensus that his work has been of such importance that his replacement is essential to its effectiveness. Contemplated plans for promotion of cancer committees in county societies throughout the state makes employment of an executive secretary necessary and desirable.

The co-operation of all organizations and individuals that have made the Committee's work effective is gratefully acknowledged.

Respectfully submitted,
W. A. HYLAND, M.D., *Co-Chairman*
C. H. KEENE, M.D., *Co-Chairman*
F. W. BALD, M.D.
M. C. BENNETT, M.D.
D. C. BURNS, M.D.
L. C. CARPENTER, M.D.
E. I. CARR, M.D.
R. C. CONNELLY, M.D.
A. B. GWINN, M.D.
A. E. HEUSTIS, M.D.
R. C. HILDRETH, M.D.
L. E. HOLLY, M.D.
A. A. HUMPHREY, M.D.
B. E. LUCK, D.D.S.
A. B. MCGRAW, M.D.
H. L. MILLER, M.D.
H. M. NELSON, M.D.
R. E. OLSEN, M.D.
H. M. POLLARD, M.D.
H. W. PORTER, M.D.
F. H. POWER, M.D.
A. W. STROM, M.D.
J. M. WELLMAN, M.D.
N. F. MILLER, M.D., *Advisor*
F. L. RECTOR, M.D., *Secretary*

ANNUAL REPORT OF THE COMMITTEE ON RHEUMATIC FEVER CONTROL—1952-53

This Committee has met five times since the last Annual Report. In addition to the routine study of the reports of the several Rheumatic Fever Diagnostic and Consultation Centers, and the reports of Leon DeVel, M.D., Medical Co-ordinator of the MSMS Rheumatic Fever Control Program, the committee has assiduously considered the educational and organizational aspects of the program.

The Committee is pleased to report the organization of two additional Rheumatic Fever Diagnostic and Consultation Centers: the Sault Ste. Marie Rheumatic Fever Diagnostic and Consultation Center, sponsored by the Chippewa-Mackinac County Medical Society, under the chairmanship of D. D. Finlayson, M.D., and the Royal Oak Rheumatic Fever Diagnostic and Consultation Center, sponsored by the Oakland County Medical Society, under the chairmanship of J. F. Pearce, M.D.

At this writing Rheumatic Fever Diagnostic and Consultation Centers are organized, sponsored, and operated by the local county medical societies in the following localities: Benton Harbor-St. Joseph, Kalamazoo, Jackson, Ann Arbor, Detroit and Wayne County (nine centers), Royal Oak, Pontiac, Lansing, Grand Rapids, Muskegon, Saginaw, Bay City, Traverse City, Petoskey, Alpena, Sault Ste. Marie, Marquette (inactive), for a total of twenty-five Centers. The cumulative Register of the several Rheumatic Fever Diagnostic and Consultation Centers as of January 1, 1953, shows a total of 3,334 registrations, each referred by the family physician for consultation and advice, 2,102 follow-up examinations, for a total of 5,436 examinations and reports to the referring physician by the several examining panels. The Alpena, Ann Arbor, Grand Rapids, Kalamazoo, Muskegon, Pontiac, Royal Oak and Traverse City Centers are to be commended for conducting the most successful programs and account for most of the achievements. The Calhoun, Genesee and St. Clair County Medical Societies have not yet joined this important educational and service program sponsored by the Michigan State Medical Society.

The Committee has prepared and distributed to the membership of the MSMS five additional "Desk Reference Cards for Rheumatic Fever" (numbers 7, 8, 9, 10 and 11) in a series designed to summarize certain phases of the rheumatic fever and rheumatic heart disease problem for ready reference by the busy physician.

An electronic amplifying stethoscope equipped with audiphone-stethoscopes for multiple listening has been purchased and placed in use in several Centers as a teaching and educational feature.

Other educational activities have included lectures and conferences on the subject of rheumatic fever and rheumatic heart disease to the following audiences: The Michigan Rural Health Conference, the Battle Creek District Nurses Association, the Chippewa Mackinac County Medical Society, the Special Teachers of the Grand Rapids Board of Education, the Kent County P.T.A. Health Institute, the Adult Education Program of the Oakland County Medical Society, the Macomb County Medical Society, the Ionia-Montcalm Nurses Association, the Oakland County District Nurses Association, the Muskegon County Nurses Association, the Wayne University Health Course for Physical Education Teachers.

Seven postgraduate fellowships for the study of rheumatic fever have been awarded for 1953. The recipients listed will attend a Comprehensive Postgraduate Course in Rheumatic Fever at St Francis Sanatorium for Cardiac Children, Roslyn, L. I., N. Y., June 1 to June 14, 1953: B. B. Bushong, M.D., Traverse City; H. E. DePree, M.D., Kalamazoo; T. R. Kirk, M.D., Petoskey; H. H. Riecker, M.D., Ann Arbor; M. J. Rueger, M.D., Detroit; J. E. Webber, M.D., Grand Rapids; and R. F. Weyher, M.D., Detroit.

A preliminary study was made of rejections by the Selective Service System, with a view of ascertaining the importance of cardio-vascular disease, and more especially rheumatic heart disease as a cause for rejection for service in the Armed Forces. In a study of 5,000 records, it was found that rejections by reason of cardiovascular disease amounted to 10.5 per cent of which 41 per cent

were rheumatic heart disease. This study was abandoned when the Committee was unable to secure the necessary funds for clerical and statistical help for its completion.

The work of this Committee is now completely and exclusively financed by grants from the Michigan Heart Association. The Michigan Heart Association in turn is a member agency of the United Health and Welfare Fund of Michigan. Earnest support of these organizations by the medical profession of the state is urged by the Committee.

The Committee on Rheumatic Fever Control hopes to merit the continued support of the House of Delegates of the Michigan State Medical Society, and indeed to every individual member of that Society in an educational and public health undertaking initiated, organized and controlled by the doctors of Michigan, for the doctors of Michigan, and for the welfare of their patients.

Respectfully submitted,
S. T. Harris, M.D., *Chairman*
P. S. Barker, M.D.
Carleton Dean, M.D.
D. D. Finlayson, M.D.
Thomas Francis, Jr., M.D.
J. H. Fyvie, M.D.
R. A. Gerisch, M.D.
M. S. Hecht, M.D.
F. D. Johnson, M.D.
B. I. Johnstone, M.D.
J. D. Littig, M.D.
E. C. Long, M.D.
L. F. McCoy, M.D.
R. J. McGillicuddy, M.D.
L. Paul Ralph, M.D.
Mr. Emmet Richards
H. H. Riecker, M.D.
D. S. Smith, M.D.
Frank Van Schoick, M.D.
L. E. Verity, M.D.
L. Fernald Foster, M.D., *Secretary*
Leon DeVel, M.D., *Medical Coordinator*

ANNUAL REPORT OF COMMITTEE ON STUDY OF GROUP HEALTH AND ACCIDENT INSURANCE—1952-53

This Committee has had several meetings to study the needs for Health and Accident Insurance for physicians of the Michigan State Medical Society and try to present a policy for the members' consideration. Different plans already in operation in many counties, health and accident policies carried by individual doctors were studied and compared. We also assembled information submitted by County Medical Societies: (1) Indicating their interest in a state-wide group insurance plan for their members. (2) Those without a County Plan. (3) Divided interest. (4) Those not interested in such plans. (5) Those who did not answer the questionnaire.

Our study showed that there is no such thing as a cheap policy. We learned that there is no standard plan that is applicable for physicians only. The existing plans seemed to apply to groups of working men without any reference to occupation. With the aid of an insurance broker, Marsh & McLennan, we drew up a set of specifications based upon:

1. Insurance reasonably obtainable: (a) Accident: Total disability—payments for five years from first day. (b) Sickness: Total disability—five years from fourth day; recommended two years from eighth to fourteenth day. We were advised that from eighth day the premium is 14 per cent higher than from the fourteenth day. The Committee felt that while many items might be desirable to many members of the profession, the rates should be kept to a minimum for the benefit of the younger practitioners.

2. The Committee thought that specific loss provision should be provided, with special emphasis on upper extremities, as loss of hand, or partial loss of hand, is worse than loss of foot.

3. Partial disability due to sickness. The Committee thought that specifications should be submitted for bids with such items included and without, so as to ascertain a comparison of cost.

4. Accidental death benefits: Instead of $10,000 maximum, we suggested $1,000 accidental death benefit for each $100 per month indemnity carried by policy holder.

5. Functional loss is to be spelled out.

6. Maximum age of entry seventy-five; maximum age insured seventy-five.

7. Schedule of benefits:

Schedule	Attained Age		Weekly Indemnity		Accidental Death
I	Through	Age 33	$50.00	Weekly	$2500.00
I-A	"	" 33	75.00	"	3500.00
II	"	" 34-49	75.00	"	3500.00
III	"	" 50-65	75.00	"	3500.00
IV	"	" 66-74	50.00	"	2500.00

The insurance and premium to be automatically changed from one schedule to another on first premium date after insured's birthday places him on next schedule.

8. Master group contract issued to Society with detailed certificate issued to insured members.

9. All members of Michigan State Medical Society, except honorary or retired members, are eligible.

10. Minimum enrollment 50 per cent of eligible members.

11. Installation procedure: Letters from Society's office followed by personal follow-up by salaried employes of insurance company without cost to the Michigan State Medical Society.

12. Many more details are in the specifications that are now in the hands of twelve first rate insurance companies who will submit proposals as to premium, rates, et cetera. When the different proposals from the several insurance companies are in hand, we shall be in a position to recommend a policy that will fulfill the needs of members of the Michigan State Medical Society for health and accident insurance. It will not be offered as a replacement of other insurance—but rather, to supplement our members' other insurance.

Respectfully submitted,
W. S. Jones, M.D., *Chairman*
L. Fernald Foster, M.D.
Mr. J. Joseph Herbert
J. D. Miller, M.D.
Arch Walls, M.D.

ANNUAL REPORT OF COMMITTEE ON INDUSTRIAL HEALTH—1952-53

The fourth "Michigan Industrial Health Day" was held March 10, in Detroit. The Committee on Industrial Health co-sponsored this annual event. E. A. Irvin, M. D., President of the Industrial Medical Association and a member of this Committee, was honored with a testimonial dinner. R. J. Hubbell, M. D., President of the Michigan State Medical Society, presented Dr. Irvin with an award for his achievement in the field of Industrial Medicine.

During the past year, committee members appeared on the programs of the Industrial Hygiene Foundation meeting, at Pittsburgh; the American Academy of General Practice, at St. Louis; the Congress of Industrial Health of the American Medical Association, in Chicago; and the Industrial Medical Association, in Los Angeles.

Your committee has been given the responsibility of arranging the program for the joint conference of the Council on Industrial Health of the American Medical Association and the Association of State Chairmen of Industrial Health Committees at the fourteenth annual

congress to be held in Louisville, Kentucky, February 23-25, 1954. Interest continues in the development of the Institute of Industrial Health at the University of Michigan. Your committee is represented by membership on the Board of Governors of the Institute.

Respectfully submitted,

M. R. BURNELL, M.D., *Chairman*
W. P. CHESTER, M.D.
E. B. CUDNEY, M.D.
W. A. DAWSON, M.D.
E. A. IRVIN, M.D.
O. J. JOHNSON, M.D.
V. S. LAURIN, M.D.
E. F. LUTZ, M.D.
I. J. MARTENS, M.D.
G. P. MOORE, M.D.
P. J. OCHSNER, M.D.
O. J. PRESTON, M.D.
D. M. RICHMOND, M.D.
N. W. SCHOLLE, M.D.
M. W. SHELLMAN, M.D.
C. D. SELBY, M.D., *Advisor*

ANNUAL REPORT OF ADVISORY COMMITTEE TO THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS—1952-53

The Committee held a meeting in April 1953, and after considerable discussion of the policies of the Foundation the following motion was passed:

"Inasmuch as the National Foundation for Infantile Paralysis has not sought the advice of the Michigan State Medical Society Advisory Committee to the National Foundation for Infantile Paralysis since October 26, 1950, and has not followed the recommendations of the Michigan State Medical Society Advisory Committee of the National Foundation for Infantile Paralysis made at that time or prior to that time, the Michigan State Medical Society Advisory Committee to the National Foundation for Infantile Paralysis recommends to the Executive Committee of The Council that this Committee be dissolved."

Respectfully submitted,

M. F. OSTERLIN, M.D. *Chairman*
E. R. ELZINGA, M.D.
H. W. HARRIS, M.D.
B. B. KING, M.D.
E. E. MARTMER, M.D.
N. R. MOORE, M.D.
F. H. PURCELL, M.D.
H. W. RIGGS, M.D.
H. H. STRYKER, M.D.
F. P. WALSH, M.D.
J. E. WEBBER, M.D.

ANNUAL REPORT OF COMMITTEE ON IODIZED SALT—1952-53

Two meetings were held during the past year. At Lansing on June 24, 1952, our Committee met with Dr. Altland and other members of the State Health Department who were interested in our iodized salt program. On October 28, our Committee met at Wayne County Medical Headquarters in Detroit with the Commissioners Nutrition Advisory Committee and subsequently held a separate meeting of our own Committee. At these meetings an active program was outlined to further publicize the need for iodized salt. These included placards for grocery stores, education of wholesale grocers, an exhibit at the State Grange Meeting and articles for Parent and Teachers, Teachers Education Association Bulletin and several other Michigan Publications. Work along these lines has continued very satisfactorily throughout the year due to the fine cooperation from the various persons and agencies in the State Health Department who are interested in goiter control.

Two articles appeared during the past year, one in THE JOURNAL OF THE MSMS and another in the *Journal of Clinical Endocrinology and Metabolism* showing the leadership of Michigan in goiter control.

Respectfully submitted,

B. E. BRUSH, M.D., *Chairman*
H. A. TOWSLEY, M.D., *Vice-Chairman*
J. B. BLODGETT, M.D.
R. B. BURRELL, M.D.
F. E. DODDS, M.D.
C. F. LEMLEY, M.D.
R. C. MOEHLIG, M.D.
D. G. PIKE, M.D.
R. L. WAGGONER, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO WOMAN'S AUXILIARY—1952-53

No problems presented themselves for solution by this Committee. Consequently, no meetings have been held.

The Committee was present as guests at the Luncheon Meeting of the Board of Directors of the Woman's Auxiliary, Wednesday, March 11, 1953, and Dr. Ivan Berlien spoke informally on that occasion.

Respectfully submitted,

IVAN C. BERLIEN, M.D., *Chairman*
A. B. ALDRICH, M.D.
W. W. BABCOCK, M.D.
W. J. BUTLER, M.D.
W. S. STINSON, M.D.

ANNUAL REPORT OF ADVISORY COMMITTEE TO THE CANCER FOUNDATION OF THE MICHIGAN FEDERATION OF BUSINESS AND PROFESSIONAL WOMEN'S CLUBS—1952-53

The Advisory Committee to the Cancer Foundation of the Michigan Federation of Business and Professional Women held no meetings during the past year. No business was referred to this Committee from the Executive Office.

Respectfully submitted,

E. I. CARR, M.D., *Chairman*
C. H. KEENE, M.D.
H. M. NELSON, M.D.
H. W. PORTER, M.D.

ANNUAL REPORT OF MEDIATION COMMITTEE—1952-53

No problems have arisen during the year 1952-1953 that required a meeting of this Committee.

Respectfully submitted,

W. Z. RUNDLES, M.D., *Chairman*
G. A. DRAKE, M.D.
A. E. GAMON, II, M.D.
E. T. MORDEN, M.D.
R. W. TEED, M.D.
CHARLES TEN HOUTEN, M.D.
E. H. TERWILLIGER, M.D.
RALPH WADLEY, M.D.

ANNUAL REPORT OF LIAISON COMMITTEE WITH MICHIGAN STATE PHARMACEUTICAL ASSOCIATION

No problems arose that required a meeting of this Committee during the year.

Respectfully submitted,

J. D. MILLER, M.D., *Chairman*
C. G. CLIPPERT, M.D.
C. W. COLWELL, M.D.
E. G. MERRITT, M.D.
G. H. RIGTERINK, M.D.

ANNUAL REPORT OF COMMITTEE ON TUBERCULOSIS CONTROL—1952-53

The principal items brought up for discussion before the Committee are as follows:

1. *TB Legislation.*—Dr. Heustis reviewed legislation introduced to date, which would affect tuberculosis institutions. This included legislation which would compel patients to be hospitalized in tuberculosis hospitals in counties in which they reside. The amount of $7,200,000 had been proposed for state subsidy for tuberculosis patients. It was also brought out that a bill has been introduced which would increase the subsidy payments for indigent patients by the amount of $1.00 per day. There was general discussion of this legislation and its effect upon the financial difficulties of both the state and local communities.

MOTION: After discussion the Committee moved that the Legislature give thought to adequate subsidy for hospitalization in approved tuberculosis institutions in Michigan in order that adequate care may be provided for the tuberculosis patients; carried.

2. *Education.*—Discussion by members of the Committee brought out the fact that there was need for elementary education of the general practitioners, particularly as regards tuberculin testing, and the processing clinically of individuals found to be suspect by means of the mobile x-ray examinations. It was suggested that a pamphlet dealing with this particular problem be prepared, and this pamphlet is to be approved by The Council of the Michigan State Medical Society and published as a joint effort of the MSMS, the Michigan Tuberculosis Association, and the Michigan Department of Health. Mr. Werle, Secretary of the Michigan Tuberculosis Association, commented that it was a basic principle of the Michigan Tuberculosis Association to finance projects helpful to the doctor in practice and the Association would be happy to continue this policy and welcome the advice and counsel of this committee. He indicated that the Michigan Tuberculosis Association facilities would be available for producing material, but that the writing, photography, et cetera, might best be done by the MSMS Committee.

MOTION: That this Committee recommends that the Michigan TB Committee prepare material for approval by the MSMS and review by the Michigan Department of Health and production by the Michigan TB Association with the understanding that this would not preclude the Michigan Tuberculosis Association from carrying on its present program; carried.

Mobile X-Ray.—The question of follow-up on mobile x-rays was raised and the need for better follow-up was pointed out.

MOTION: That the Committee recommends that one television program of the MSMS deal with the follow-up of mobile x-ray findings; carried.

The co-operation of county medical societies in educational programs which would make better follow-up of the mobile x-ray is needed, the Committee felt. It is recommended that the Committee prepare a sample program for county medical societies complete with films, discussion leaders, et cetera, to put life behind the literature mentioned above. Mr. Werle stated that the Michigan TB Association would pay for the cost of physicians to visit county medical societies to tell the story from the physician's point of view. It was generally agreed that the effectiveness of the follow-up program depended to a great extent upon the interest shown by the local medical groups, and it was further pointed out that care should be taken so that the physician-patient relationship should not be disturbed. Discussions brought out the fact that the follow-up program was effective in proportion to the prevailing x-ray rates in the community served.

MOTION: That recognizing certain weaknesses in the follow-up program of mobile x-ray units probably due to administrative problems in getting information to medical doctors and back, and also due to lack of recognition of necessity for follow-through, this Committee recommends that more active participation of county medical societies through television, education programs, and literature be sought by those conducting the survey; carried.

MOTION: That the Tuberculosis Committee recommends that Michigan Health Council be requested to assist in implementing the educational program by way of its television program "The Court of Health" and in any other way possible using the advice jointly of the MSMS, the Michigan Department of Health and the Michigan Tuberculosis Association.

3. *Issue of JMSMS for Diseases of the Chest.*—This suggestion was given enthusiastic discussion.

MOTION: That this Committee requests that the March 1954, issue of THE JOURNAL MSMS be devoted to diseases of the chest; carried.

4. *TB Sanatorium Bed Study.*—Dr. Isbister presented a copy of this study.

5. *TB Recodification.*—An attempt was begun to consider the areas of disagreement existing in the proposed recodification of the TB laws. Since this bill is not to be introduced this year and the hour was late the Committee decided to give no further consideration to this question.

MOTION: That further consideration of these points be deferred to a later date.

Respectfully submitted,
J. W. TOWEY, M.D., *Chairman*
P. T. CHAPMAN, M.D.
F. M. DOYLE, M.D.
J. L. EGLE, M.D.
J. F. FAILING, M.D.
W. B. HOWES, M.D.
J. L. ISBISTER, M.D.
C. E. LEMMON, M.D.
G. T. MCKEAN, M.D.
C. J. STRINGER, M.D.

ANNUAL REPORT OF THE LIAISON COMMITTEE WITH MICHIGAN VETERANS' ORGANIZATIONS —1952-53

The entire discussion at the one meeting of this committee on November 25, 1952, was the problem of securing beds for the growing number of veterans with tuberculosis and/or neuropsychiatric disorders. The State of Michigan has been discriminated against in this regard and the result has been either lack of hospitalization or the occupancy of beds in otherwise short supply at the expense of county or state budgets—a situation which the Congress never intended. Despite two visits by members of the committee to Washington and the sincere co-operation of members of the Michigan Congressional delegation, it appears that the new 500-bed Veterans Hospital at Ann Arbor will be operated as a general hospital for which there is no demonstrable need currently, and that a partial conversion of 300 beds at the Dearborn Veterans Hospital for the care of the tuberculous, essentially withdraws this number of active general beds from the area where there is the greatest density of veteran populace.

Respectfully submitted,
WILLIAM BROMME, M.D., *Chairman*
R. H. BAKER, M.D.
G. W. SLAGLE, M.D.
MR. J. W. CASTELLUCCI, *Advisor*

ANNUAL REPORT OF THE COMMITTEE ON ATOMIC AND ALLIED PROCEDURES—1952-53

This committee was circularized in the fall of 1952, and a request made for material to be placed on the agenda for a meeting. The response was so poor and disheartening that it was decided to abandon the meeting until some future date.

Respectfully submitted,
ARTHUR A. HUMPHREY, M.D., *Chairman*
H. F. BECKER, M.D.
O. A. BRINES, M.D.
J. E. COLE, M.D.
K. H. CORRIGAN, Ph.D.
J. J. GREBE, Ph.D.
L. E. HOLLY, M.D.
TRAIAN LEUCUTIA, M.D.
H. B. LEWIS, Ph.D.
M. L. LICHTER, M.D.
A. B. McGRAW, M.D.
W. L. MALLMANN, Ph.D.
L. L. QUILL, Ph.D.
W. J. NUNGESTER, M.D., *Advisor*

ANNUAL REPORT OF THE MENTAL HYGIENE COMMITTEE, 1952-53

The Mental Hygiene Committee has been active, having five general meetings as well as two sub-committees on special assignments. On recommendation of the Committee, the Michigan State Medical Society has submitted to members of the Legislature a definition of the term Psychiatrist for use in the preparation of any statute involving the activity of a psychiatrist.

Reports by Dr. Dorsey of the Detroit Committee on Narcotic Addiction and by Dr. Heldt of the State Board of Alcoholism, were studied by the Mental Hygiene Committee. Consideration was also given at a number of the Committee meetings to the question of recommendations regarding the teaching of mental health in public schools. The possibility that the existing program of the State Medical Society might be augmented has been considered.

The advisability of including a psychiatric question in the license examination given by the State Board of Registration in Medicine was discussed at length. It was the feeling of the Committee that such a question or questions should be a part of the examination leading to the licensing of physicians in the State of Michigan.

The problem of fee schedules for psychiatric services was discussed and a tentative fee schedule was submitted to the State Medical Society for recommendation to the Michigan Medical Service. This fee schedule was also presented to the Michigan Society for Neurology and Psychiatry for their consideration and was later approved by that body.

On query from the AMA Committee on Mental Health, copies of the Mental Hygiene Committee Annual Reports for the last five years were sent to the AMA for their consideration as representing the program of the Mental Hygiene Committee.

The attitude of various insurance companies concerning the issuing of malpractice insurance policies for psychiatrists was discussed at length. It is understood that the American Psychiatric Association and the Michigan State Society for Neurology and Psychiatry are also considering this serious problem. This action of the insurance carriers apparently is based upon the assumed dangers of electro-shock therapy.

There was much discussion of the practice of psychotherapy by other than licensed physicians. On request of Dr. McIntyre, Secretary of the State Board of Registration in Medicine, the Attorney General issued an opinion indicating that any person practicing psychotherapy was in fact practicing medicine and must be therefore licensed to practice medicine. After thorough discussion, the Committee endorsed by resolution the opinion of the Attorney General.

The Chairman of your Committee is very appreciative of the interest and support of the Committee members during this past year, and it is our hope that the activities of the Mental Hygiene Committee have been of some assistance to the Michigan State Medical Society.

Respectfully submitted,
R. W. WAGGONER, M.D., *Chairman*
I. C. BERLIEN, M.D.
C. W. BRADFORD, M.D.
W. E. CLARK, M.D.
F. P. CURRIER, M.D.
W. W. DICKERSON, M.D.
J. M. DORSEY, M.D.
G. C. FINK, M.D.
T. J. HELDT, M.D.
L. E. HIMLER, M.D.
M. H. HOFFMAN, M.D.
R. F. KERNKAMP, M.D.
L. A. LaCORE, M.D.
M. H. MARKS, M.D.
F. O. MEISTER, M.D.
H. A. LUCE, M.D., *Advisor*
E. M. WILLIAMSON, M.D.

ANNUAL REPORT OF COMMITTEE ON EMERGENCY MEDICAL SERVICE—1952-53

In the past year this Committee has met as a whole on November 19, 1952, and January 2, 1953. In addition, the Sub-Committee on Training Program for Medical and Para-Medical Personnel met May 30, 1952, and the Committee on Planning and Organization met December 10, 1952. Also there have been several informal meetings of small groups from these Committees at the chairman's office and home.

We have recommended that the final medical civil defense plan of the state be built around those plans of our cities which have been developed and are in working order at the present time. The Detroit plan has been considered with interest by the Federal Civil Defense Group.

We have recommended that the State be divided into sub-divisions, corresponding to the councilor areas of the MSMS, with each having one or more representatives who will meet with the Emergency Medical Service Committee. This has been approved by The Council. These physicians will be requested to stimulate the development of medical civil defense planning locally, patterned after a state-wide plan. They would look to the Emergency Medical Service Committee, for guidance and in turn would keep the committee aware of progress and problems.

We have further recommended that a medical secretary be employed by the State Office of Civil Defense to work for that office with the Emergency Medical Service Committee of the Michigan State Medical Society and the Michigan Department of Health. The duties of this Secretary would be to co-ordinate and implement the activities of these groups in working out a medical plan satisfactory to the Michigan State Medical Society.

Several new members have been added to the Committees and Sub-Committees during the year. We believe by this time next year a well developed plan can be effected.

Respectfully submitted,
WILLIAM H. GORDON, M.D., *Chairman*
W. H. ALEXANDER, M.D.
C. P. ANDERSON, M.D.
A. G. BAKER, M.D.
W. J. FULLER, M.D.
A. C. FURSTENBERG, M.D.
R. F. HAGUE, M.D.
S. W. HARTWELL, M.D.
F. W. HYDE, JR., M.D.
LOUIS JAFFE, M.D.
E. F. KICKHAM, M.D.
M. L. LICHTER, M.D.
J. D. MILLER, M.D.
T. E. SCHMIDT, M.D.
G. H. SCOTT, Ph.D.
W. A. STRYKER, M.D.

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

A TUBERCULOSIS MILESTONE

In 1952, for the first time in Michigan's history, tuberculosis was missing from the ten leading causes of death, according to provisional mortality figures for that year. Tuberculosis deaths recorded in the state in 1952, totaled 776 in comparison with 1,154 in 1951 when this disease was the eighth cause of death.

It was pointed out by Dr. Heustis, however, that there is no cause for complacency. Looking beyond the death rates to the facts and figures on cases, there is no evidence that tuberculosis is under control. There is no reduction in the number of newly reported cases. More patients are now hospitalized than ever before in our history. More than two-thirds of the patients entering Michigan sanatoria have advanced disease. The case finding program has lagged far behind the more spectacular and popular hospital building program.

Of the 203,860 persons x-rayed by state health department mobile x-ray units in 1952, one out of every thirty-five showed signs of chest abnormalities; one out of 100 showed evidence of possible tuberculosis; and one out of 200 showed evidence of possible active tuberculosis.

Two of the department's mobile units are at present working in the Upper Peninsula, on the plan adopted some time ago of giving better service by surveying one-half of the Peninsula in the spring and one-half in the fall.

HEALTH DIRECTOR FOR HOUGHTON-KEWEENAW-BARAGA

C. A. E. Lund, M.D., took up his duties as director of the Houghton-Keweenaw-Baraga Health Department on June 15. Dr. Lund went to the Copper Country from Middleville, Michigan, where he has been in practice for several years.

VENEREAL DISEASES STILL A MAJOR PROBLEM

A recent study of the incidence of syphilis and gonorrhea in Michigan emphasizes that, in spite of advances in treatment, the venereal diseases are still far from being under control. In 1952, over 7,300 cases of syphilis were reported, an increase of 13 per cent over the number of 1951. Reported cases of gonorrhea dropped from about 8,400 in 1951 to 7,700 in 1952.

The department's control program concentrates on two areas—helping to find the early cases and to make sure that the infected person gets adequate treatment to prevent late complications.

In promoting case finding, the department has been co-operating with the U. S. Public Health Service and the Detroit City Health Department in a training program in interviewing techniques. The effectiveness of training is proved by the fact that, prior to the program, interviewers were able to learn of an average of only 1.69 sources and contacts of each infected person. After the training program had been in operation for eighteen months, the average had risen to 4.29 sources and contacts, two-and-a-half times as many.

TRI-COUNTY HEALTH DEPARTMENT FORMED

Grand Traverse, Leelanau and Benzie counties joined, effective May 1, to form the Grand Traverse-Leelanau-Benzie District Health Department. Gerald W. Behan, M.D., will serve as director of the new unit and the main office will be in Traverse City. The Department will serve a population of 45,385.

This does not alter the number of local health departments in Michigan. It still stands at forty-eight, with sixteen multiple-county departments. It is another step forward in the continuing process of combining and recombining counties for more effective public health service.

FLUORIDATION PROGRESSES

Two more Michigan communities, St. Joseph and Tecumseh, have voted to fluoridate their public water supplies. This brings to twenty-nine the number of Michigan cities furnishing this protection to their children.

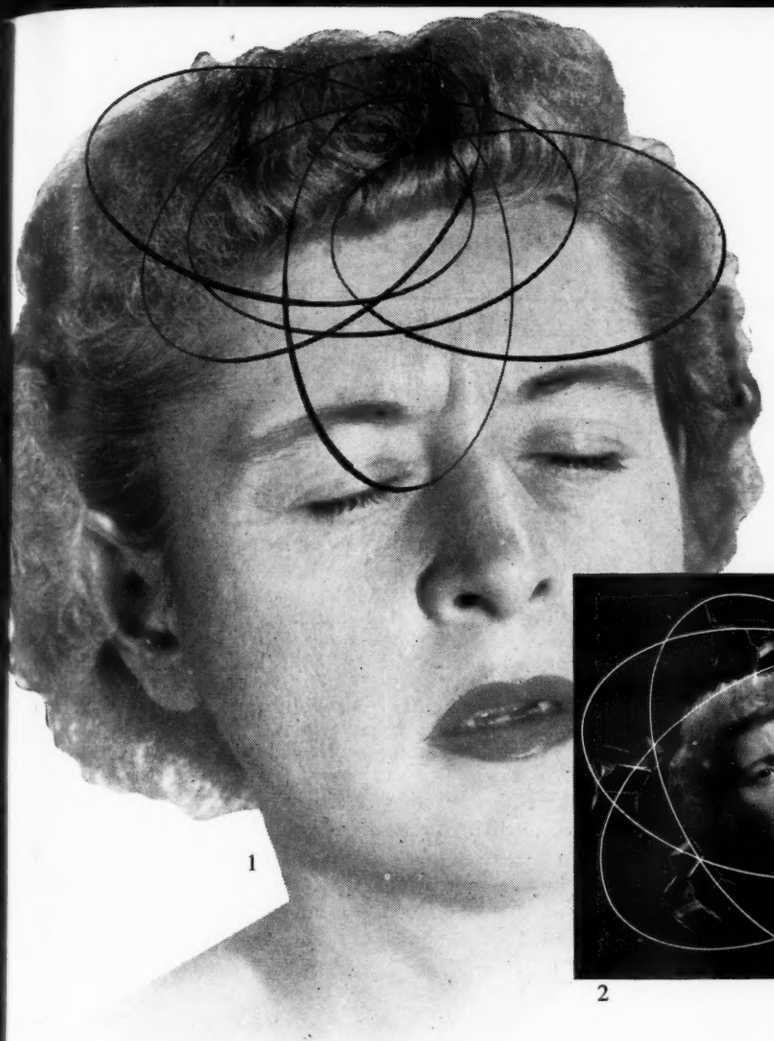
MEDICAL EXTERN PROGRAM TO BE REPEATED

Plans are being made to repeat the medical extern program carried on by the department for the first time last summer. Four medical students from the University of Michigan were hired for summer work.

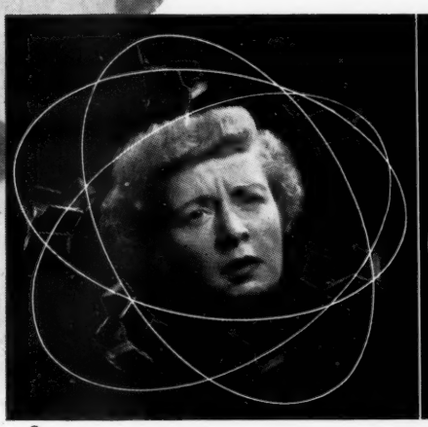
The objective of the program is to give the students actual experience in public health work and to provide a few health departments with special medical personnel during the summer months. Both students and health departments felt that they benefited from the summer training experience.

WEIGHT CONTROL TO BE FEATURED IN THEATERS

A good many Michigan theater patrons will learn about weight control this summer through an 8-minute animated color cartoon, "Cheers for Chubby." The film, produced for the Metropolitan Life Insurance Company which also handles the theater bookings, has been well received by Michigan theater managers. An interestingly large number of drive-in theaters are booking the film.



1. *Dizziness . . . movement is within the head.*
2. *Objective vertigo . . . the environment is in motion.*
3. *Subjective vertigo . . . the patient himself moves in space.*



2

3

TYPES OF VERTIGO:

Their symptomatic relief with Dramamine®

The disagreeable sensations of dizziness which physicians are frequently required to explain to patients have been described by Simonton[1] as varying from a slight sensation of confusion to severe vertigo.

While dizziness or giddiness is classified as a sensation of unsteadiness with a feeling of movement within the head, in vertigo the environment seems to spin (objective vertigo) or the body to revolve in space (subjective vertigo). Labyrinthine disturbances are likely to cause a sensation of rotation. Among the more common causes of dizziness or vertigo, this author lists: Damage to the vestibular nuclei or tracts in the central nervous system, involvement of the vestibular end organs by disease of the ear, Ménière's disease, toxicity of drugs, ocular vertigo from sudden diplopia, visual field defects, looking down from heights and motion sickness due to hyperactive labyrinthine reaction from riding in vehicles.

Dramamine (brand of dimenhydrinate) has proved effective in treating many of these disturbances. The indications for which Dramamine is now Council accepted include: Motion sickness, the nausea and vomiting associated with pregnancy, certain drugs, electroshock therapy and narcotization; vestibular dysfunction associated with streptomycin therapy; the vertigo of Ménière's syndrome, hypertensive disease and that following fenestration procedures, labyrinthitis and radiation sickness.

1. Simonton, K. M.: The Symptom of Dizziness, Arizona Med. *6*:28 (Sept.) 1949.

SEARLE *Research in the Service of Medicine*

Legal Opinions

PRACTICE OF CHIROPODY

Wm. J. Burns, Executive Director
Michigan State Medical Society
Lansing, Michigan

Dear Mr. Burns:

Reference is had to a recent inquiry which you have referred to me for opinion.

Your inquirer states in his letter as follows:

"One of the Sanitarium patients went down to one of the chiropodists in Battle Creek for relief of a bunion and has been given hypodermic shots (to tone her muscles and also shots to treat a dermatitis of her leg and ankle). Some time ago she had phlebitis and since then has an irritated skin of her leg and ankle, which if she rubs it breaks out with a rash. This man has been treating it by hypodermics.

"Are those treatments allowed under his license?"

Where the practice of chiropody ends and the practice of medicine or surgery begins in a particular case, is by no means simple to determine. There is no reported case in our state which indicates the distinction nor the line of demarcation. We must, therefore, have reference to the Chiropody Act (Act 115, P.A. 1915; M.S.A. 14.661 et seq.), and attempt to give it a reasonable construction.

In the first section of that act a chiropodist is defined as follows:

"Within the meaning of this act, a chiropodist sometimes called podiatrist, is defined as one who for hire or reward examines, diagnoses and treats abnormal nails, superficial excrescenses occurring in the hands and feet, including corns, warts, callosites, bunions and arch troubles or one who treats medically, surgically, mechanically or by physiotherapy, ailments of the human foot."

In Section 2 of the same act there is a proviso.

"That said certificate of qualification or license shall not authorize chiropodist to amputate the human foot or toes, or to use or administer anaesthetics other than local."

From the reading of these provisions, it would seem that not only is the chiropodist permitted to examine, diagnose and treat abnormal nails, superficial excrescences, etc., occurring on the hands and feet, but he is also permitted to treat medically, surgically, mechanically, or by physiotherapy, "ailments of the human foot," with the limitation that he is not authorized to amputate the foot or toes, or to use a general anaesthetic.

If the treatment by hypodermics indicated on the letter to you is for the purpose of treating an "ailment of the human foot," it would seem to be authorized under the act. However, I am not in position to state whether the particular case is one which may be considered "an ailment of the human foot." That is a medical conclusion. If the ailment is not essentially one of the human foot, then the chiropodist is not authorized to treat it in any manner. This approach, of course, leaves open

(Continued on Page 790)

A Marked Advance in

oral estrogen therapy

no odor or after-odor

no taste or aftertaste

Now, after years of search . . . a *pure* crystalline salt of the conjugated natural estrogen, estrone.

HOW has this tasteless, odorless therapy shown in clinical trial?..."The facility with which dosage can be regulated . . . and the rapidity with which relief can be obtained on minimal medication are commendable."[1]

SIDE EFFECTS? From a report on 58 standardized menopausal patients . . ."Nausea was extremely uncommon, being observed in only . . . one patient on Sulestrex."[2]

ESTHETIC? "The annoying urinary taste and odor, sometimes found in natural conjugated estrogen, is not present."[3] Make *your* test of SULESTREX—soon. Available in Tablets and Elixir.

Abbott

SULESTREX® Piperazine

(Piperazine Estrone Sulfate, Abbott)

3-1678

1. Reich, W. J. et al. (1951), A Recent Advance in Estrogenic Therapy. I. Amer. J. Obst. & Gynec., 62:427, August. 2. Perloff, W. H. (1951), Treatment of the Menopause. II. Amer. J. Obst. & Gynec., 61:670, March. 3. Reich, W. J. et al. (1952), A Recent Advance in Estrogenic Therapy. II. Amer. J. Obst. & Gynec., 64:174, July.

(Continued from Page 788)

the question whether a condition which is not local to the foot, but may be a general or systemic one, manifesting itself in the foot, as well as in other parts of the body, would or should be regarded as "an ailment of the human foot." This also I regard as a medical question which would be decided by a court only upon expert testimony of medical men.

Hence, the only opinion I can afford in this matter is that if in the opinion of competent medical practitioners, the ailment for which the chiropodist gives hypodermic treatment is essentially an ailment of the human foot, then he is within the authority granted by statute.

Very truly yours,
J. Joseph Herbert
Legal Counsel

May 19, 1953

* * *

FEES FOR SURGICAL ASSISTANTS

L. Fernald Foster, M.D.
Secretary, MSMS
Lansing, Michigan

Dear Doctor Foster:

Under the date of May 6, 1953, you transmitted to me for opinion an inquiry from a member of the Michigar State Medical Society, as follows:

"In this community as there is no resident staff at the hospital, a surgeon asks another physician to act as his surgical assistant. For this service the surgeon pays his assistant a fee, usually whether he is paid or not. We are concerned as to whether this is considered fee splitting. If so, and if the surgeon and his assistant are required to submit separate statements, what arrangements can be made in cases covered by Blue Cross and other insurance plans that pay but one fee to the surgeon?"

The American College of Surgeons in its publication "The Minimum Standard for Hospitals" defines fee splitting as follows:

"Fee splitting is a transaction for financial gain practiced under contract, understanding, or by consent—silent or spoken—through which a portion of the compensating fee that a specialist or practitioner receives from the patient (presumably for his own services) is paid directly or indirectly to another individual or agent who was influential or instrumental in bringing the patient to the specialist or practitioner for operation or treatment."

M. T. MacEachern, M.D., formerly executive director of the American College of Surgeons, in an article entitled "The Board's Control of Hospital Medical Care," which appeared in the April, 1950, issue of *Trustee*, listed nine principles which every physician on being appointed to the medical staff of a hospital should be required to ascribe. The ninth of these principles is given as follows: "A surgeon who has a regular assistant at operations may pay him directly. When the assistant has referred the patient to the operating surgeon, he should follow the procedure outlined in the third of these principles."

(Continued on Page 803)

In Memoriam

JOHN D. ADCOCK, M.D., of Ann Arbor, died May 10, 1953, at the age of forty-four.

He was assistant professor of internal medicine at the University of Michigan Medical School. He first joined the medical staff of the University in 1938 as an assistant resident in the tuberculosis unit and became an instructor in 1940. He left Michigan in 1941 to join the staff of the University of Pennsylvania Hospital at Philadelphia. He returned to Michigan in 1943 to assume his present position.

Dr. Adcock was graduated from the University of Pennsylvania School of Medicine in 1935. He was a member of the American College of Physicians and the American Trudeau Association.

He is survived by his wife, Margaret, a son, John, and his mother.

MELVIN E. CHANDLER, M.D., of Flint, died April 25, 1953, at the age of eighty-one.

Until his retirement three years ago, Dr. Chandler had served the community of Flint since 1908. He was graduated from the University of Michigan Homeopathic Medical School in 1906.

Dr. Chandler interned at the University Hospital and then practiced for a year in Mount Pleasant before coming to Flint. He was a life member of the Michigan State Medical Society and a member of the Genesee County Medical Society. He was also a member of the American Homeopathy and Michigan State Homeopaths organizations.

He is survived by a daughter, Mrs. Clarence Shedd, of Flint.

ARTHUR J. JONES, M.D., of Detroit, died April 22, 1953, at the age of seventy-two.

For the past forty-five years, Dr. Jones had practiced medicine in Detroit. He was graduated from the University of Michigan Medical School in 1907. He was on the staff of St. Joseph Mercy Hospital and East Side General Hospital.

Dr. Jones was a member of the Wayne County Medical Society and a Life member of the Michigan State Medical Society.

He is survived by two sons, Robert S. Jones and Arthur S. Jones; a sister, Mrs. Norman D. Cooper; and seven grandchildren.

WILLIAM H. PARKS, M.D., of Petoskey, died April 14, 1953, at the age of sixty-five.

From 1925 to 1951 he practiced medicine in Petoskey. He was graduated from Wayne University College of Medicine in 1912. Doctor Parks was a former chief of staff of Lockwood General Hospital.

Besides his wife, Violet, he is survived by one son and four daughters. They are William H. Parks, Jr., of Petoskey; Mrs. Charles I. Miller, of Lafayette, Ind.; Mrs. Guy Conkle, Jr., Boyne City; Mrs. Sibley Felton, of

(Continued on Page 794)

WILLIAM H. PARKS

(Continued from Page 792)

Grand Rapids; and Miss Mary Parks, of Lafayette, Ind. He also leaves seven grandchildren.

WM. J. RYNEARSON, M.D., of Fenton, died April 12, 1953, at the age of sixty-five.

For the past thirty years, he had served the community of Fenton as a general practitioner. Previous to that, Dr. Rynearson had practiced in Hartland after his graduation from Wayne University College of Medicine in 1912. He was a member of the Genesee County Medical Society and was active in civic affairs. He had served as a member of the Fenton Board of Education for nine years and also was health officer for the community of Fenton for a number of years.

During World War I, Dr. Rynearson served as captain in the Medical Corps, with the 32nd Division. He was awarded the Silver Star.

Besides his wife, Alberta, he is survived by four daughters and three sons. They are Mrs. Patricia Knecht, of Pennsylvania; Mrs. Geraldine Matulavitch, Miss Grace Ann Rynearson, and Mrs. Mary Ruth Stevenson, all of Detroit. The sons are William Rynearson, Jr., and Richard Rynearson, who are in the armed forces, and Thomas Rynearson of Mt. Pleasant. He also leaves three brothers and two sisters and eight grandchildren.

CLYDE C. SLEMONS, M.D., of Grand Rapids, died May 7, 1953, at the age of seventy-nine.

Dr. Slemons was Health Commissioner for the Michigan Department of Health from 1930 to 1938. He also served as Grand Rapids City Health Officer from 1910 to 1930 and again from 1941 to 1952 when he retired.

Dr. Slemons was graduated from Wayne University College of Medicine in 1905. He was a member of the Kent County Medical Society and a life member of the Michigan State Medical Society. Dr. Slemons was also a Fellow of the American Public Health Association.

In Grand Rapids, Dr. Slemons pioneered in the adding of iodine to the water supply to combat goiter and set up Grand Rapids' first clinic for infant feeding. As State Health Commissioner, Dr. Slemons was credited with reorganization of the Health Department and with establishing full-time health departments in twenty-four counties.

He is survived by his wife, Isabella; two daughters, Anne and Marian L. Slemons, M.D., of Braintree, Mass., and a brother, Elmer J. Slemons, all of Grand Rapids.

HARRY STOCKER, M.D., died May 5, 1953, at the age of fifty-six.

Dr. Stocker was graduated from Northwestern University Medical School in 1923. He had practiced medicine in Detroit for thirty years.

Dr. Stocker was a member of the Wayne County Medical Society.

Besides his wife, Devera, he is survived by a daughter, Mrs. Frank Titus; a son, Jack; a brother, Ben; and two sisters, Mrs. Morris Pearl and Mrs. Maurice Mitshkun.

. . . . . NEWS MEDICAL

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
Pantlind Hotel-Civic Auditorium, Grand Rapids
Wednesday-Thursday-Friday, September 23-24-25, 1953
YOU ARE URGED TO ATTEND!

Status of all Hill-Burton Hospital construction in Michigan, as of May 1, 1953:

Completed and in Operation.—Twenty-six projects —total cost of $21,636,341 (including federal contribution of $8,123,893) and supplying 1,466 additional beds.

Under Construction.— Sixteen projects — total cost $16,860,708 (including federal contribution of $6,417, 777), designed to supply 849 additional beds.

Approved but Not Yet Under Construction.—Five projects—total cost of $5,051,700 (including $1,620,300 federal contribution), designed to supply 321 additional beds.

* * *

Michigan Delegates to the AMA House of Delegates gained extraordinary recognition this year with four important committee appointments:

W. D. Barrett, M.D., Detroit—Chairman of Committee on Officers' Reports.

G. C. Penberthy, M.D., Detroit—Chairman of Committee on Executive Session.

R. A. Johnson, M.D., Detroit—Member of Committee on Officers' Reports.

W. H. Huron, M.D., Iron Mountain—Member of Hygiene and Public Health Commission.

* * *

The New York Academy of Medicine announces its 26th Graduate Fortnight—October 19-30, 1953, on "Disorders of the Blood and the Blood-Forming Organs." For program, write the Academy at 2 East 103 Street, New York 29, N. Y.

* * *

The American Diabetes Association will launch its sixth nationwide health education and case-finding program during "Diabetes Week"—November 15-21.

William LeFevre, M.D., 289 W. Western Avenue, Muskegon, is chairman of the Sub-Committee on Diabetes Control of the Michigan State Medical Society which will spearhead the Diabetes Week drive in this State.

* * *

The State Bar of Michigan featured in its April, 1953, "Medical Jurisprudence Number" articles by the following Michigan doctors of medicine: Alfred H. Whittaker, M.D., on "The Beaumont Memorial," John R. Pedden, M.D., Grand Rapids, on "The Question of Traumatic Carcinogenesis," John H. Schlemer, M.D., Detroit, on "Artificial Insemination and the Law," George K. Swartz, M.D., Battle Creek, on "Psychiatry and the Courts."

The MSMS Legal Counsel, Mr. J. Joseph Herbert, Manistique, also had an article in the current law journal on "Does the Law Seal the Doctor's Mouth?"

* * *

CIO still fights for socialized medicine.—The CIO *News* of May 11, under the banner line "Stunted Lives Are the Price of AMA Scare Drive" made this statement:

"A national social insurance system in the field of health, along the lines labor has been demanding, remains the sound approach in spite of political difficulties."

* * *

Edwin DeJongh, M.D., Detroit, was recently elected a director of the Industrial Medical Association at its national convention in Los Angeles. Dr. DeJongh is Medical Director of the Detroit Diesel Engine Division of General Motors Corporation.

* * *

The American College of Surgeons has established the first of several contemplated scholarships in the field of research for promising young men seeking a career in academic surgery. Successful candidates receive $20,000 over a three-year period. Inquiries may be addressed to Research Scholarship Committee, American College of Surgeons, 40 E. Erie Street, Chicago 11, Illinois.

* * *

The Wayne County Medical Society's Annual Golf Tournament will be held at Tam O'Shanter Country Club on Tuesday, August 4, 1953. The WCMA Golf

(Continued on Page 798)

Thanks are expressed by JMSMS to the John Hancock Mutual Life Insurance Company for the plates used to create the four-color reproduction of painting on the cover of the April JMSMS. This beautiful color photograph of the jurist was processed on THE JOURNAL cover at very little expense, thanks to the generous loan by the John Hancock Mutual Life Insurance Company of its valuable plates.

Tournaments were originated in 1930 and usually attract some 300 medical golfers.

* * *

The Wayne County Medical Society Telephone Service, inaugurated in February, 1953, is on a self-supporting basis. Approximately 300 Detroit and Wayne County M.D.'s are subscribers to this 24-hour telephone service which during the first three months of operation handled 1,026 messages for doctors, answered 3,735 queries from the public regarding subscribing doctors' hours, days off, phone numbers, et cetera, and also handled 2,232 emergency calls.

A very active serviceable infant!

* * *

The AMA Council on Medical Education and Hospitals has nine full-time doctors of medicine on its staff. Each staff member has been assigned a geographical area and will review, on a biannual basis, the internship and residency programs of approved hospitals.

* * *

F. D. Dodrill, M.D., Detroit, was guest speaker at the Student American Medical Association annual convention in Chicago, June 15-17, 1953.

* * *

AMEF contributions nearing a million dollars.—More than 8,600 contributors have donated in excess of $702,000 to the American Medical Education Foundation during the first quarter of 1953. The goal for this year is $2,000,000.

* * *

Wm. J. Burns, MSMS Executive Director, spoke on "Exhibits—Your Opportunity in Physician Participation" at the 1953 Blue Cross-Blue Shield Conference in Hollywood, Fla.

* * *

Aging Pilots.—Old airplane pilots don't even fade away. They just keep pushing 'em on through. And these pilots are becoming something of a problem to aviation.

There now are more than 1,000 civilian pilots in this

(Continued on Page 800)

The complex interrelation of the social and the medical in the tuberculosis problem comes sharply into focus in the patient who leaves the sanatorium against medical advice.

Probably no one has greater influence in the adjustment of the tuberculosis patient to his hospitalization than his own family physician. His explanations—his advice—carry weight with the patient facing hospitalization, which can later be reinforced by others of the medical-social team.

But, for good or ill, the physician who diagnoses the case and refers the patient for sanatorium care begins the "education" of the patient. A good beginning will eliminate many problems of adjustment.

—MICHIGAN TUBERCULOSIS ASSOCIATION

(Continued from Page 798)

country past the age of 60, Dr. Ross A. McFarland of Harvard university school of public health told the world meeting of the Aero Medical Association.

But the senior fliers still are doing a good job. A study of 60 civilian air crashes shows that pilot aging had nothing to do with the crackups. Tests show that older persons are less affected by high altitude than youngsters. At 16,000 feet the young ones faint more quickly than their elders, he said.

Failing eyesight, Dr. McFarlane added, is more of a hazard in automobile driving than in piloting planes.

Of the more than 1,000 men over 60 flying civilian planes, twelve are airline pilots, sixteen are commercial fliers, and the others operate privately owned planes.

* * *

The World Health Organization budget for 1954 is $8,497,700. This budget consists of assessments against the seventy Active Member states and three Associate Members.

* * *

Injury Rate in Atomic Energy Program Reduced.—The injury rate in the nation's atomic energy program decreased by one-third in 1952, the U. S. Atomic Energy Commission announced. Injuries in the program during 1952 occurred at a rate of 2.51 per million employe-hours—33.3 per cent below the 1951 figure. The rate for all United States industry in 1951, the latest available from the National Safety Council, was 9.06 injuries per million employe-hours.

Operations contractors in the atomic energy program set a rate of 2.29 employes injured per million man-hours, compared to 2.69 in 1951. The NSC 1951 rate for the chemical industry, the nearest comparable, was 5.48.

The rate for Government-owned motor vehicles was 1.4 accidents per 100,000 miles driven by employes of AEC and its contractors in 1952, compared with 1.6 in 1951.

Fatalities likewise were reduced, dropping from twenty-four in 1951 to eleven in 1952. None was due to radiation. Nine occurred in construction, one in a motor vehicle accident, and one in loading a heavy generator which fell.

* * *

Wayne University received a grant recently from Eli Lilly and Company.

The grant will support a predoctorate fellowship in organic chemical research under the direction of Dr. Carl Djerassi, associate professor of chemistry at Wayne University.

* * *

Books on Banned List.—Twenty-one books by fifteen authors had been removed from library shelves of the United States Information Service here since the State Department issued a weeding out directive March 18. The list includes Edwin Seaver's *Pageant of American Humor* and Bernhard J. Stern's *American Medical Practice* and *Government Medical Service.*

The original directive was described as banning "the works of all Communist authors, any publication con-

tinually publishing Communist-propaganda and questionable material lending undue emphasis to Communist personalities or their statements."

* * *

List Total AMA Membership at 140,000.—In writing and in speaking, physicians and others in the health field often refer to the total membership in the American Medical Association. The figure quoted often ranges all the way from 125,000 to 160,000. Since the total figure is used and referred to so often it might be well, for the sake of uniformity, to adopt a round number, and thereby avoid confusion in the public's mind.

The correct figure, based on the December 31, 1952, records of the Membership Division of the AMA Department of Records and Circulation is 140,000.

Here is a breakdown of that figure:

126,000—active members (including those exempted from the payment of AMA dues).

9,000—service members (full-time commissioned officers in the regular Army, Navy, Air Force, U. S. Public Health Service, Indian Service, and Veterans Administration).

5,000—associate members (physicians who hold a type of membership in a constituent association that does not give them the right to vote and hold office).

* * *

New High For Profession.—There were 214,667 doctors in the United States at the end of 1952, more than at any other time in history, the American Medical Association announced.

A report by the Council on Medical Education and Hospitals of the AMA said there was an increase of 2,987 doctors in the U. S. during 1952.

In the eighteen-year period from 1935 to 1952 there have been 110,700 doctors added to the medical profession. The AMA said this is the result of an increase in medical teaching facilities, accelerated medical school programs, and the licensing of foreign-trained doctors.

At the close of 1952 there were 151,363 doctors engaged in private practice; 6,677 were in full-time research and teaching; 28,366 were interns, residents and physicians working in hospital administration. Another 8,166 doctors were retired and 20,095 are in government service.

* * *

The Students American Medical Association held a conference in Chicago June 15, 16 and 17, 1953. On the program were the following:

Warren Wilkins, M.D., of Grand Rapids, gave the Keynote Address.

J. S. De Tar, M.D., of Milan, gave a talk, part in symposium on General Practice as a Speciality.

F. D. Dodrill, M.D., of Detroit, gave a talk about "the Michigan Heart" demonstrating the Artificial Heart.

* * *

Social Security.—In Cleveland, June 3, Arthur J. Altmeyer, former Federal Commissioner of Social Security, was nominated president-elect of the National Conference of Social Work, the largest organization in the United States devoted to health and welfare activities. He will take office as president next year.

Mr. Altmeyer declared that President Eisenhower's Administration "could not change the Social Security system even if it wanted to."

Mr. Altmeyer became a member of the Social Security Board in 1935 and served as its chairman from February, 1937, to July, 1946, when he was appointed Commissioner. His job was abolished last April when the former Federal Security Agency was reorganized as the Department of Health, Education, and Welfare under Secretary Oveta Culp Hobby.

The former Commissioner declared in the interview that he believed the country would "improve and extend our contributory social insurance system to provide more adequate protection to more people from more of the major economic hazards which cause widespread hardship and suffering."

* * *

Mental Health TV Program.—"Our Modern Mind," a thirteen-week series on mental health, began June 7 on WJBK-TV, Detroit. It is presented each Sunday at 12 noon in cooperation with the Michigan Department of Mental Health and the Northville State Hospital. The television series is designed to shed some light on the unfortunate misunderstandings that exist about mental illness.

WJBK-TV has turned over its complete facilities as a public service for the programming of the series. Still pictures, film sequences and studio presentations are

being used. Doctors of medicine and other experts in the field of mental health are appearing on the program. The show has a news documentary style.

Efforts are under way to publish a brochure regarding the series which will be distributed to the viewing audience. It is expected the pamphlet will be available about August 15.

* * *

LEGAL OPINIONS

(Continued from Page 790)

The third "of these principles" reads as follows: "Each doctor concerned in the care of the patient should give or send directly to the patient a detailed statement showing charges for professional services rendered."

There is no doubt that the gist of the offense is in splitting the fee with the person who referred the patient to the operating surgeon. Hence, it is my opinion that the situation which the member describes would not be fee splitting unless the assistant were the one who referred the patient to the operating surgeon.

In response to the latter part of the doctor's inquiry, it is my information that Blue Shield pays but one fee for an operation and does not pay for an assistant.

Very truly yours,

J. Joseph Herbert
Legal Counsel

May 18, 1953

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

CONTACT DERMATITIS. By George L. Waldbott, M.D., F.A.A.A., F.A.C.A., F.I.A.A., F.A.C.P., Senior Physician, Harper Hospital Chief of Division of Allergy; Assistant Physician, Grace Hospital Chief of Allergy Clinic; Formerly, Director of Allergy Clinic Children's Hospital of Michigan; Formerly, Consultant Allergist, St. Mary's Hospital and North End Clinic, Detroit, Michigan. Springfield, Ill.: Charles C Thomas, 1953.

This monograph by an author practicing in Detroit, Michigan covers the important subject of Contact Dermatitis which is the most common of the cutaneous diseases. He considers all phases such as incidence, pathology, diagnosis and treatment but more of the detail concerns the pattern of location on the skin. The book is profusely illustrated with examples of these patterns which should be a great help in the detective work required so often in determining the cause of a contact dermatitis. This book is highly recommended to those interested in the subject.

H.E.A.

PATHOLOGY OF THE HEART. Edited by S. E. Gould, M.D., D.Sc., Clinical Professor of Pathology, Wayne University College of Medicine, Detroit, Michigan; Pathologist, Wayne County General Hospital, Eloise, Michigan; Consultant in Pathology, Veterans Administration Hospital, Dearborn, Michigan; Editor, American Journal of Clinical Pathology. Springfield, Ill.: Charles C Thomas, 1952. Price $25.50.

This volume must be considered as being the first of its kind devoted to the pathology of the heart and is more than deserving of the somewhat hackneyed term of monumental. Readers of THE JOURNAL will be interested to know that of the thirteen collaborators, five are residents of Michigan, including the editor.

The sections on the development of the heart are very good and in particular the discussion on post-natal circulatory changes. The anatomy is presented in far better detail than in the most complete text on that subject and the illustrations are excellent and numerous. A thorough and extensive bibliography is appended to each chapter and as an example the one following the part on cardiac physiology is amazing in its scope and length. Outstanding sections of a generally excellent book are the ones dealing with abnormal cardiac function and its clinical application, the text and illustrations concerning malformations, coronary sclerosis including studies on prognosis, and the one on myocarditis which lists some rarely encountered and interesting conditions.

The clinical correlation is excellent and thus it recommends itself not only to pathologists and cardiologists but to any physician who performs a cardiac examination.

A.A.H.

POLIOMYELITIS. Papers and Discussions Presented at the Second International Poliomyelitis Conference compiled and edited for the International Poliomyelitis Congress. Philadelphia: J. B. Lippincott Co., 1951. Price $7.50.

This volume is a compilation of the papers and discussions presented at the Second International Poliomyelitis Conference held in Copenhagen, Denmark, September, 1951. It is a review of the progress in the knowledge of poliomyelitis since the first international congress held in 1948, for the purpose of providing workers in the field with a source book which will help to avoid costly duplication of work already done.

Much of the work is highly technical and is primarily compiled for those in the field of research. The discussions in particular, however, are interesting to the general medical reader.

The book is well illustrated, especially with the exhibits in the latter part of the book dealing with rehabilitation measures and is printed on glossy paper with good format.

This work is a valuable asset to the library of those with special interests in the field of polio and viral diseases.

R.W.B.

THE CIBA COLLECTION OF MEDICAL ILLUSTRATIONS. Volume I, Nervous System, A compilation of Pathological and Anatomical Paintings prepared by Frank H. Netter, M.D., with a foreword by John F. Fulton, M.D., Sterling Professor of the History of Medicine, Yale University School of Medicine. Summit, New Jersey: Commissioned and published by Ciba Pharmaceutical Products, Inc., 1953. Price $6.50.

All physicians are acquainted with the anatomical paintings of Dr. Frank Netter. We all know how beautiful and lucid is his work of art. To make this work more complete and useful the publishers have included an accompanying descriptive text discussing the illustrations. The Anatomy of the Spine, The Central Nervous System and the Pathology of the Brain and Spinal Cord are ably discussed by Abraham Kaplan, Clinical Professor of Neurosurgery, New York Polyclinic Medical School and Hospital. The section in functional neuroanatomy is presented by G. Von Bonin, Professor of Anatomy, University of Illinois College of Medicine. The section on the Autonomic Nervous System is described by Albert Kuntz, Professor of Anatomy, St. Louis University School of Medicine. Dr. John F. Fulton, in his foreword, states, "This is a work of consistently high quality. Ciba Pharmaceutical Products, Inc., in offering this new volume in their series of anatomical illustrations (at cost price), adds another to their enviable list of contributions to the progress and history of medicine." Every student of the nervous system will thank the publishers for providing such a clear and complete portrayal of the system in one atlas at the price within the reach of all.

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